GROUP HEALTH INSURANCE PLAN
CERTIFICATE BOOKLET

HDHP 2 Plan

WMI Mutual Insurance Company

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RENEWAL

This Plan is guaranteed renewable at the option of the Policyholder on the Policyholder's annual renewal date provided the premiums are paid and all eligibility provisions of the Policy are satisfied.

TABLE OF CONTENTS **Page**

I. Schedule of Benefits

A. **COMPREHENSIVE MAJOR MEDICAL EXPENSE PLAN:** The following services and treatments are covered at the benefit levels set forth below subject to the terms, limitations, and exclusions of the policy.

1. **Individual Annual Deductible and Individual Annual Out-of-Pocket Benefits (These amounts are applicable to an insured Individual who is enrolled on single coverage ONLY. If two (2) or more persons are enrolled on the coverage, please refer to the section entitled Family Deductible and Family Out-of-Pocket Benefits for the applicable amounts):**

   (a) **Individual Annual Deductible (single coverage only):**

   HDHP Plan: $1,500

   Except as specifically set forth in this Schedule of Benefits or the Policy, the Insured individual must satisfy the individual Annual Deductible before any benefits under this Policy are paid. Only amounts paid by the insured individual toward Eligible Charges are applicable to the satisfaction of the Deductible (except where otherwise specified in the Policy).

   (b) **Individual Annual Maximum Out-of-Pocket Payout:**

   HDHP Plan: $3,000

   (1) Eligible charges will be paid at **100%** by the Company during any Calendar Year in which the applicable Out-of-Pocket amount has been satisfied.

   Only Deductible and co-insurance amounts that are incurred by the insured individual person during the Calendar Year will be applied toward the satisfaction of the Individual Annual Maximum Out-of-Pocket. Amounts paid for non-covered care or treatment do not apply toward the Individual Annual Maximum Out-of-Pocket.

   (2) Benefits for Prescription Drugs will always be paid in accordance with the Prescription Drug Benefit. Prescription Drug costs are applicable to, and subject to, the annual maximum Out-of-Pocket amounts.

2. **Family Deductible and Family Out-of-Pocket Benefits (these amounts are applicable when two (2) or more persons are enrolled on the coverage):**

   (a) **Annual Maximum Family Deductible:** The Annual Maximum Family Deductible must be satisfied in each Calendar Year before any Benefits will be paid for any person enrolled on the coverage. The Family Deductible is an aggregate amount and contributions towards the Family Deductible can be made by any covered person.

   HDHP Plan: $3,000

(b) **Annual Family Out-of-Pocket:**

HDHP Plan: $6,000

(1) Eligible charges will be paid at **100%** by the Company during any Calendar Year in which the applicable Family Out-of-Pocket amount has been satisfied. The Family Out-of-Pocket amount is an aggregate amount and contributions towards the Family Out-of-Pocket amount can be made by any covered person.

Only Deductible and co-insurance amounts that are paid by the Insured or Dependent during the Calendar Year will be applied toward the satisfaction of the Family Out-of-Pocket maximum. Amounts paid for non-covered care or treatment do not apply toward the Family Out-of-Pocket maximum.

(2) Benefits for Prescription Drugs will always be paid in accordance with the Prescription Drug Benefit. Prescription Drug costs are applicable to, and subject to, the annual maximum Out-of-Pocket amounts.

3. **Percentage of Eligible Charges payable after satisfaction of Deductible and prior to the satisfaction of the Out-of-Pocket maximum amounts for Inpatient Hospital, Outpatient Hospital, Surgical Services, Medical Services and Services for Mental Illness. These benefits are subject to and eligible to be paid at 100% up to the maximum benefit once the applicable maximum Out-of-Pocket amount is satisfied.**

(a) **PPO Network Percentage Payable After Deductible** (unless otherwise specified in the Policy or in this Schedule of Benefits): **60%**

(b) **Non-PPO Network Percentage Payable After Deductible** (unless otherwise specified in the Policy or in this Schedule of Benefits): **45%**

(c) **Pre-Deductible Benefit for Eligible Charges For Non-PPO Preventive and Wellness Services, including Routine Physical examinations, Routine Check-ups, and Routine Immunizations:**

Non-PPO Preventive and Wellness Services, including Routine Physical examinations, Routine Check-ups, and Routine Immunizations are not subject to the Calendar Year Deductible unless and until the Company has paid a total of **$500** toward these services. The percentage payable for these services is as described elsewhere in this Schedule of Benefits for each corresponding service. Amounts paid by the Insured for these services prior to the satisfaction of the $500 Benefit do not apply toward the satisfaction of the Deductible amount.

(d) **Organ Transplants and Joint Implants:**

(1) Category I organ transplants and joint implants as defined in the Policy are subject to the General Limitations and Exclusions applicable to major medical expense Benefits. Category I organ transplants and joint implants must be pre-authorized by the Company in writing. The allowable amount for Implantable Hardware used for a joint implant is limited to 300% of the invoice cost, as set

forth elsewhere in the Schedule of Benefits. 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 transplant are paid provided that the recipient of the transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under a recipient's coverage (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.

(2) Category II organ transplants must be pre-authorized by the Company in writing, and may require a consistent second opinion, (and third opinion), if requested by the Company). For the purpose of this Benefit, any transplant therapy or protocol involving bone marrow shall constitute one organ even if multiple transplants are performed. The allowable amount includes payment for all transplant related costs including, but not limited to, all hospital, surgical, and medical expenses for an eligible transplant. Eligible diagnostic, medical and surgical expenses for a compatible live or cadaveric donor that are directly related to the transplant are paid provided that the recipient of the transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under a recipient's coverage (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. A period of eighteen (18) months must transpire before a benefit shall be allowed for a different eligible Category II organ transplant.

(e) **Implantable Hardware:** The maximum allowable amount for Implantable Hardware, as defined in the Policy, is limited to 300% of the invoice cost. An invoice showing the actual cost of the implant must be submitted to the Company.

(f) **Ambulance services:**

Inside PPO Network:	**60%**
Outside PPO Network:	**45%**

(g) **Durable Medical Equipment:** Except as set forth below, eligible expenses are paid at **50%** and are subject to all other Policy provisions including, but not limited to, Usual and Customary allowances or PPO network allowances.

1. Eligible expenses for pain management pumps and infusion-type pumps will be paid at **50%**. This limit applies regardless of whether the pumps are internal or external.

2. Eligible expenses for insulin pumps (whether internal or external) and pacemakers are paid at the levels as for any other major medical expense.

(h) **Back and spine manipulations and modalities:**

Inside PPO Network:	**60%**
Outside PPO Network:	**45%**

of Eligible Charges subject to a maximum Benefit payment of **$2,000** per Calendar Year. The maximum benefit limitation for visits does not apply for treatment rendered within six (6) months of a spinal surgery.

(i) **Prosthetics:** For a natural limb or eye which is lost while insured, only the initial prosthesis is eligible for payment at **50%**.

(j) **Circumcisions** performed within thirty (30) days of birth or adoption are covered up to a maximum of **$150**.

(k) **Sleep Studies.** Eligible expenses are paid to a lifetime maximum of **$1,000.**

(l) **Treatment for sleep apnea.** Eligible expenses that are not Essential Benefits are paid to a lifetime maximum of **$5,000**. The maximum benefit limitation **includes**, but is not limited to, surgical procedures. The maximum benefit limitation **does not include** oxygen or Durable Medical Equipment.

(m) **Treatment for Diabetes.** Expenses related to diagnosis, monitoring, treatment, control, and education for self-management of diabetes, such as education and medical nutrition therapy, medicines, equipment and supplies are paid at **60%** (**except** for equipment that meets the definition of Durable Medical Equipment, which is paid under the Durable Medical Equipment benefit as otherwise stated in this Schedule of Benefits).

(n) **Office Visits:**

Inside PPO Network:.. 60%
Outside PPO Network: 45%

(o) **Laboratory Charges and X-Rays:**

Inside PPO Network:.. 60%
Outside PPO Network: 45%

4. **Preventive and Wellness Services, including Routine Physical Examinations, Check-ups, and Immunizations**: If the following services are provided by a **PPO Provider**, Benefits are not subject to the Calendar Year 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 Calendar Year Deductible (unless otherwise specified) and are paid with regular cost-sharing by the Insured (unless otherwise specified).

(a) Screening and tests with a rating of A or B in the U.S. Preventive Services Task Force for prevention and chronic care. **A list of the specific eligible services is attached to this Plan.** Certain preventive medications are covered. This includes, but is not limited to, aspirin, fluoride, iron, and tobacco cessation products. These medications must be obtained with a Prescription Order in accordance with the guidelines that are set forth in the U.S. Preventive Services Task Force.

Inside PPO Network: 100%

Outside PPO Network: 45%

(b) Immunizations that are for routine use in children and in adolescents, and influenza immunizations for any age. Benefits are subject to the guidelines that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. **A list of the specific eligible services is attached to this Plan.**

Inside PPO Network: 100%
Outside PPO Network: 60%

(c) Immunizations that are for routine use in adults are covered. Benefits are subject to the guidelines that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. **A list of the specific eligible services is attached to this Plan.**

Inside PPO Network: 100%
Outside PPO Network: 45%

(d) Services, tests and screenings that are contained in the U.S. Health Resources and Services Administration Bright Futures guidelines for infants, for children, and for adolescents are covered. **A list of the specific eligible services is attached to this Plan.** These guidelines are as set forth by the American Academy of Pediatricians.

Well baby care is never subject to the Calendar Year Deductible, **even if the $500 maximum Benefit for pre-Deductible procedures has been met,** and amounts paid by the Insured for these procedures are not applicable to the satisfaction of the Deductible. Benefits are payable at the following percentages:

Inside PPO Network: 100%
Outside PPO Network: 60%

Benefits for well child care and adolescent care are payable at the following percentages:

Inside PPO Network: 100%
Outside PPO Network: 45%

(e) Services, tests, screening and supplies that are recommended in the U.S. Health Resources and Services Administration preventive and wellness guidelines for women are covered. **A list of the specific eligible services is attached to this Plan.** Benefits include, but are not limited to, all contraceptive methods that are approved by the Food and Drug Administration ("FDA"). This includes insertion or extraction of contraceptive devices that are approved by the FDA. Benefits also include tubal ligation.

Inside PPO Network: 100%
Outside PPO Network: 45%

(f) Other wellness services that are not set forth in the above guidelines are covered. This includes Routine Physical Examinations and check-ups.

Inside PPO Network: 100%
Outside PPO Network: 45%

(g) A colonoscopy is covered and it is subject to the following guidelines that are in accordance with the American Cancer Society:

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

ii. 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.

Inside PPO Network: 100%
Outside PPO Network: 45%

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

Inside PPO Network: 100%
Outside PPO Network: 45%

B. **PRESCRIPTION DRUG BENEFIT:**

Eligible Prescription Drugs are payable at the benefit level set forth below subject to the same terms and conditions of the major medical Deductible and maximum Out-of-Pocket amounts. Prescription Drug claims are ineligible for payment at the retail pharmacy and must be submitted directly to the Company for reimbursement. Specialty and biotech medications that are considered to be self-injectable (such as, but not limited to, Avonex, Betaseron, Enbrel, Fuzeon, Imitrex, Humira, Intron, and Rebif) will be paid under the Prescription Drug Benefit even if they are administered by a Provider. All Policy provisions apply to this Benefit. Expenses related to diabetes, including insulin, testing supplies, and syringes, are paid as major medical expenses as set forth in the Schedule of Benefits and not as Prescription Drug Benefits. The Company is entitled to any and all available rebates that are paid by Prescription Drug manufacturers.

1. **Deductible Per Person:**

HDHP Plan: Included in major medical Deductible

2. **Prescription Drug Member Co-Insurance:**

Generic: 25%
Brand: 50%

Notwithstanding the prescription drug benefits as shown above, the prescription insulin drugs shown in each of the following categories will be paid at the Generic co-insurance level:

a) Rapid acting: (1) FIASP; (2) Novolog
b) Regular (short acting): (1) Novolog 70/30; (2) Novolin R
c) Intermediate acting: (1) Novolin N; (2) Novolog Mix 70/30
d) Long acting: (1) Tresiba; (2) Levemir; (3) Basaglar
e) Ultra long acting: (1) Tresiba; (2) Levemir; (3) Basaglar
f) Combination/pre-mixed: (1) Novolin 70/30; (2) Soliqua 100/33; (3) Xultophy 100/3.6
g) Inhaled: Afreeza

C. **MENTAL ILLNESS CARE AND TREATMENT OF ALCOHOL OR SUBSTANCE ABUSE:**

Eligible expenses for the following are subject to the Calendar Year Deductible and amounts paid by the Insured for these procedures are applicable to the Out-of-Pocket amount**:**

1. **Inpatient and Outpatient Mental Illness Care:**

Inside PPO Network:	**60%**
Outside PPO Network:	**45%**

2. **Inpatient and Outpatient treatment for Alcohol or Substance Abuse:**

Inside PPO Network:	**60%**
Outside PPO Network:	**45%**

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, that is independent of disease or bodily infirmity and for which the Insured is not entitled to receive any Benefits under any Worker's Compensation or Occupational Disease Law. Physical damage resulting from chewing is not considered an Accident.

"Actively at Work" and **"Active Work"** means being in attendance in person at the usual 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, eligibility will not be denied if the Employee is absent from work due to a health factor, however, work must begin before coverage will become effective.

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

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

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

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

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

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

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

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

"Company" means the WMI Mutual Insurance Company.

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

"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.

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

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

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

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

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

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

"Date Incurred" means the date services were provided.

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

"Dependent(s)" includes any of the following:

(a) The lawful spouse of an Insured Employee.

(b) The Insured Employee's (or the Insured Employee's Spouse's) Child(ren), under age twenty-six (26); and

(c) A Child who has reached the limiting age for termination of coverage, who is unable to engage in substantial gainful employment to the degree that the Child can achieve economic independence due to a medically determinable physical or mental impairment, which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, and who is chiefly dependent upon the Insured for support and maintenance. Proof of such incapacity must be submitted within thirty (30) days of such Dependent's attainment of the limiting age. The Company may require at reasonable intervals during the two (2) years following the Child's attainment of the limiting age subsequent proof of his incapacity. After the two (2) year period, subsequent proof may not be required more than once each year.

"Disability or Disabled" means a physiological or psychological condition that partially or totally limits an individual's ability to: (a) perform the duties of: (i) that individual's occupation; or (ii) an occupation for which the individual is reasonably suited by education, training, or experience; or (b) perform two or more of the following basic activities of daily living: (i) eating; (ii) toileting; (iii) transferring; (iv) bathing; or (v) dressing. 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.

(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, the term, "Effective Date" shall mean 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.

"Eligible Charges" means those charges incurred by an Insured Employee or Insured Dependent for which coverage is available under the terms and conditions of the Policy.

Eligible Charges for PPO expenses are based on negotiated fee schedules; Eligible Charges for non-PPO expenses are based on the Usual and Customary rate as determined by the Company.

"Emergency" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention at a Hospital emergency department to result in: (i) placing the Insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

"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 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.

"Essential Benefits" means: 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; and 10) Pediatric services, including oral and vision care. There are no annual or lifetime dollar limits applicable to essential benefits provided the services are otherwise eligible for Benefits under this Plan. Any benefit-specific dollar limits referenced in the Schedule of Benefits pertain only to those health care services and supplies that are not essential benefits.

"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, substance abuse or alcoholism, is not considered an "Extended Care Facility/Rehabilitation Care Facility."

"Family Deductible" means the aggregate amount as listed in the Schedule of Benefits that must be satisfied in each Calendar Year before any Benefits will be paid for any person enrolled on the coverage.

"Family Out-of-Pocket" means the aggregate amount as listed in the Schedule of Benefits that must be satisfied before any Eligible Charges for any covered person will be paid at 100% by the Company. Only eligible Deductible and co-insurance amounts that are paid by the Insured or Dependent during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Amounts paid for non-covered care or treatment do not apply toward the Out-of-Pocket maximums.

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

"Health Savings Account" or "HSA" means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary subject to the requirements of Internal Revenue Code §223(d).

"High Deductible Health Plan" or "HDHP" means a health plan: (1) that has an annual deductible which is at least: (a) $1,400 for self-only coverage (as indexed by federal law), and (b) twice the dollar amount in subclause (1)(a) for family coverage; and (2) the sum of the annual deductible and the other annual out-of pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed: (a) $6,900 for self-only coverage (as indexed by federal law), and (b) twice the dollar amount in subclause (2)(a) for family coverage. The definition of a High Deductible Health Plan or an HDHP is subject to the requirements of Internal Revenue Code §223(c)(2).

"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 is licensed which operates within the scope of such license.

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

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

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

"Injury" 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 worker's 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.

"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 health care services or products that a prudent health care professional would provide to an Insured for the purpose of preventing, diagnosing or treating an Illness, Injury, disease or its symptoms in a manner that is:

(a) In accordance with generally accepted standards of medical practice in the United States;

(b) Clinically appropriate in terms of type, frequency, extent, site and duration;

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

(d) Covered under the Policy.

When a medical question of fact exists, medical necessity shall include the most appropriate available supply or level of service for the Insured individual that is known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established interventions, the effectiveness shall be based on (i) Scientific Evidence; (ii) professional standards; and (iii) expert opinion.

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

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

"Mental Health Care Practitioner" means an individual licensed by the state as a Physician or surgeon, or osteopathic Physician engaged in the practice of mental health therapy; an advanced practice registered nurse, specializing in psychiatric mental health nursing; a psychologist qualified to engage in the practice of mental health therapy; a clinical social worker; a certified social worker; a marriage and family therapist; or a professional counselor.

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

psychosexual disorder; chronic organic brain syndrome; personality disorder; specific developmental disorder or learning disability; or an intellectual disability.

"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.

"Out-of-Pocket" means the maximum dollar amount per year of Eligible Charges payable by an Insured to Providers. Only eligible Deductible and co-insurance amounts that are paid by the Insured during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Amounts paid for non-covered care or treatment do not apply toward the Individual Annual Maximum Out-of-Pocket. The Out-of-Pocket amounts are specified in the Schedule of Benefits section of this booklet.

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

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

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

"Policyholder" means the Employer named on the Certificate.

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

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

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

"Preferred Provider Network", "Network" or "PPO" means a network of Providers that contract with a Preferred Provider Organization to provide services to Insureds of the Company at negotiated rates.

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

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

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

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

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

(a) Resident beds or residential units;

(b) Supervisory care services (general supervision, including the daily awareness of resident functioning and continuing needs);

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

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

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

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

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

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

"Schedule of Payment" means an amount determined by the Company.

"Scientific Evidence" means:

(a) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(b) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

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

"Special Enrollment" means an enrollment period, other than the Employer's initial enrollment period or annual Open Enrollment period, when 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.

"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. For the purpose of air Ambulance services, the Usual and Customary amount shall be limited to 250% of the amount that is allowed by Medicare.

"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. Employees must enroll in the Plan prior to the Employer's Effective Date. In order to enroll, Employees must submit 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 cannot enroll in the Plan until the next Open Enrollment period.

B. **ELIGIBILITY DATE FOR NEWLY HIRED EMPLOYEES:** Newly hired Employees are eligible to participate in this Plan on the following dates:

1. If the Employer has selected a Waiting Period of 60 days or less, coverage will become effective on the first day of the month following the satisfaction of the Employer's Waiting Period.

2. If the Employer has selected a Waiting Period of 90 days, coverage will become effective on the first day of the month preceding the satisfaction of the Employer's Waiting Period.

A new Employee must submit a properly completed enrollment card to the Company before coverage can become effective. Any eligible Employee who does not enroll within thirty-one (31) days after satisfying the Waiting Period of the Employer cannot enroll in the Plan until the next Open Enrollment period. An eligible Employee will be considered a Late Enrollee at that time.

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 must submit a properly completed enrollment card to the Company to enroll in the Plan. 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 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. 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 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 exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, coverage through this Plan must be requested within sixty (60) days after the termination. An individual who voluntarily cancels other health coverage or ceases to pay premiums for such other coverage is not eligible for special enrollment rights and must wait until the Open Enrollment period to enroll.

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 thirty-one (31) 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 lost the other coverage. If the other coverage is COBRA coverage, the Dependent may only enroll after the COBRA coverage has been involuntarily exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, coverage through this Plan must be requested within sixty (60) days after the termination. An individual who voluntarily cancels other health coverage or ceases to pay premiums for such other coverage is not eligible for special enrollment rights and must wait until the Open Enrollment period to enroll.

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 thirty-one (31) days of eligibility.

   b. A newborn Child is automatically covered from the moment of birth for a period of thirty-one (31) days and an adopted Child is automatically covered

from the date the Child is placed for the purpose of adoption for a period of thirty-one (31) days. If the payment of a specific premium is required to provide coverage for a newborn or adopted Child, the Insured Employee must enroll the eligible Child within thirty-one (31) days from the date of birth or placement for adoption and must pay all applicable premium within the thirty-one (31) day period, in order for the coverage of a newborn or adopted Child to extend beyond the thirty-one (31) day period. If the payment of a specific premium is not required to provide coverage for a newborn or adopted Child, the eligible Child will be automatically enrolled upon receipt of a claim.

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

E. **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. Active Employees must 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 fewer than three (3) Employees eligible for insurance the Company requires 100% participation of all eligible Employees, and if there are fewer than ten (10) Employees the Company requires 75% participation of all eligible Employees. The Company may terminate this Plan for failure to meet participation requirements on any premium due date by giving written notice to the Policyholder at least thirty-one (31) days in advance.

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 if the Employee's individual insurance terminates.

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

3. An Employee's insurance under this Plan may be immediately terminated if he has performed an act or practice that constitutes fraud. An Employee's insurance under the Plan may also be terminated if he has made an intentional

misrepresentation of material fact under the terms of the coverage. The Company will provide a 30-day advance notice to the Insured prior to such rescission or termination. In addition, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

B. **TERMINATION OF DEPENDENT 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 the Definitions section of the Policy.

2. The date the Employee's 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.

4. A Dependent's insurance under this Plan may be immediately terminated if he has performed an act or practice that constitutes fraud. A Dependent's insurance may also be terminated if he has made an intentional misrepresentation of material fact under the terms of the coverage. The Company will provide a 30-day advance notice to the Insured prior to such rescission or termination. In addition, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

C. **EXCEPTIONS TO THE TERMINATION OF DEPENDENT COVERAGE 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. A Child who has reached the limiting age for termination of coverage, who is unable to engage in substantial gainful employment to the degree that the Child can achieve economic independence due to a medically determinable physical or mental impairment, which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, and who is chiefly dependent upon the Insured for support and maintenance, will have Benefits continued during such period of incapacity. Proof of such incapacity must be submitted within thirty (30) days of such Dependent's attainment of the limiting age. The Company may require at reasonable intervals during the two (2) years following the Child's attainment of the limiting age subsequent proof of his incapacity. After the two (2) year period, subsequent proof may not be required more than once each year.

V. COVERED SERVICES: This Policy provides the following Benefits as set forth in the Schedule of Benefits.

A. **INPATIENT FACILITY SERVICES:** The Medical Necessity of the length of stay of all Inpatient facility services must be Pre-Certified. Pre-certification is recommended for Urgent Care but it is **not** required. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. The company that must be contacted for Pre-certification is shown on the insurance card. They must be contacted before all admissions that are not emergencies. Emergency admissions must be reported within twenty-four (24) hours after the Insured's condition has stabilized, or as soon as reasonably possible. Failure to comply will reduce all Benefits for the Inpatient facility services by 10%. **Pre-certification does not guarantee that payment will be made nor does it determine that Benefits are eligible.** If an Insured receives an adverse Pre-certification determination in which Benefits are denied in whole or in part, he may contact the Company to request a review. The review will be conducted in accordance with the provisions as established by applicable law.

1. Inpatient Hospital Daily Rate (other than Intensive Care Unit). 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. The Plan limits Hospital stays to a maximum duration of three hundred sixty-five (365) days per Disability.

2. Inpatient Hospital Services. The Plan covers all necessary Hospital supplies and services for three hundred sixty-five (365) days for each Disability. Room charges are covered as a separate expense.

3. Inpatient Hospital Intensive Care Unit. Covered Expenses that are incurred in a Hospital Intensive Care Unit are covered up to a maximum of one hundred eighty (180) days for each Disability.

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

5. Inpatient Alcohol or Substance Abuse Treatment, including residential treatment. Eligible expenses are covered as set forth in the Schedule of Benefits. Treatment must be rendered in an Alcohol/Substance Abuse Dependency Treatment Center as defined in the Policy and must also meet all other criteria for eligibility subject to all other terms and provisions of the Policy in order for Benefits to be provided.

6. Inpatient Extended Care Facility/Rehabilitation Care Facility. The eligible amount for the daily room charge incurred at an Extended Care or Rehabilitation

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

B. **OUTPATIENT HOSPITAL SERVICES:** Outpatient services, supplies and treatment that are provided in an ambulatory service facility will be paid as set forth in the Schedule of Benefits.

C. **OUTPATIENT TREATMENT FOR MENTAL ILLNESS:** Outpatient Mental Illness care expenses that are eligible are covered as set forth in the Schedule of Benefits. Care must be rendered by a Mental Health Care Practitioner or in a Mental Health Care Facility as those terms are defined in the Policy in order to be eligible for Benefits. Treatment rendered by a Mental Health Care Practitioner or in a Mental Health Care Facility must also meet all other criteria for eligibility subject to all other terms and provisions of the Policy in order for Benefits to be provided.

D. **GENERAL SURGICAL SERVICES (other than organ transplants, implants, and joint implants):** The Plan covers surgical procedures performed by the primary surgeon as set forth in the Schedule of Benefits.

1. One surgical assistant is covered for each surgery. The services of a surgical assistant are only covered if they are Medically Necessary. Payment is limited to 20% of the amount that is allowable for the primary surgeon's charges.

2. 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 time and 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 lessor 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.

3. The Plan also covers one co-surgeon for each surgery. The services must be Medically Necessary. The co-surgeon must also be licensed under a different specialty than the primary surgeon. The total 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.

E. **MEDICAL SERVICES:**

1. Physician Consultations:

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

(b) Consultations that are requested by the attending Physician are covered. One consultation is allowed for each specialist for each Disability.

(c) Limitations. One Physician or Provider Visit is allowed for each day. Benefits will expire after three hundred sixty-five (365) days (180 days for intensive care) of Hospital confinement for each Disability.

(d) Concurrent Physicians Services:

(i) A patient who is hospitalized for a surgical procedure and who receives Hospital medical care from a Physician other than the surgeon for a different condition is entitled to both the Hospital Physician care Benefit and the Benefit for the surgical service.

(ii) A patient who is admitted to the Hospital for a medical condition and is then transferred to the Hospital's surgical service for the same condition but under the care of another Physician, is entitled to Hospital Physician Benefits only from the date of admission to the date of transfer to the surgical service. Thereafter, the patient is only entitled to the Benefit for surgical services unless the surgery performed is diagnostic, a myelogram, or endoscopic procedure.

(iii) In the event the patient receives concurrent Hospital care from more than one Physician during the same admission (whether or not it is for the same condition), the patient is entitled to Benefits for services of only the attending Physician. If the Company determines that due to the medical complexity of the patient's condition the services of more than one Physician were required, the services provided by the additional Physician will be covered.

2. The Plan covers mammograms as set forth in the Schedule of Benefits.

3. The Plan covers routine physical examinations as set forth in the Schedule of Benefits.

4. The Plan covers immunizations as set forth in the Schedule of Benefits.

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

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

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

"Reconstructive breast surgery" means surgery performed as a result of a mastectomy to establish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy. Physical complications of mastectomy, including lymphedemas, are also covered.

Benefits for reconstructive breast surgery include, but are not limited to, prostheses and physical complications with regards to all stages of mastectomy, including lymphedemas.

F. **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.

G. **ORGAN TRANSPLANTS AND JOINT IMPLANTS:**

1. Organ Transplants and Joint Implants are covered as set forth in the Schedule of Benefits. All such services must be pre-certified by the Company in writing. All transplants or implants may require a second opinion (and a third opinion), if deemed necessary by the Company, and will be paid by the Company. If the required Pre-certification is not obtained, all Hospital payments will be reduced by 10%. The following organs and body parts are eligible for transplant or implant:

   (a) Category I - Heart, arteries, veins, intra-ocular lenses, corneas, kidneys, skin, tissues, and all joints of the body.

   (b) Category II – (i) Heart/lung combined; (ii) liver; (iii) lung (single or double); (iv) pancreas; and (v) bone marrow, stem cell rescue, stem cell recovery, any and all other procedures involving bone marrow or bone marrow components as an adjunct to high dose chemotherapy, including services related to any evaluation, treatment or therapy involving the use of myeloablative chemotherapy with autologous hematopoietic stem cell and/or colony stimulating factor support (MC-AHSC/CSF).

For the purpose of Category II benefits, the following terms are defined as follows: (i) "Myeloablative Chemotherapy" means a dose of chemotherapy which is expected to destroy the bone marrow; (ii) "Autologous Hematopoietic Stem Cell" means an infusion of primitive cells capable of replication and differentiation into mature blood cells which are harvested from the Insured's blood stream or bone marrow prior to the administration of the myeloablative chemotherapy; (iii) "Colony Stimulating Factor" means a substance which increases the reproduction, differentiation, and maturation of blood cellular components.

All organs for 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.

2. Organs and body parts not specifically listed in Category I and Category II, including but not limited to, intestines are ineligible for transplant or implant Benefits.

H. **DIAGNOSTIC LABORATORY TESTS AND X-RAY EXAMINATIONS:** Expenses for laboratory tests, x-rays, pathological services, or machine diagnostic tests will be paid as set forth in the Schedule of Benefits. These services must be authorized by a Physician and be required as the result of an Injury or Illness.

I. **ANESTHESIA SERVICES:** The Plan covers anesthesia service to achieve general or regional (but not local) anesthesia. This service must be at the request of the attending Physician 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. Services of a nurse anesthetist are covered only if they are Medically Necessary and if a Hospital employee or Physician is unavailable.

J. **OUTPATIENT ALCOHOL OR SUBSTANCE ABUSE TREATMENT:** Outpatient treatment for alcohol or substance abuse treatment is covered as set forth in the Schedule of Benefits.

K. **MATERNITY SERVICES:**

1. Maternity Benefits are paid on a Dependent spouse or an Employee the same as Benefits paid on any other Illness. 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. Maternity coverage does not include an Insured's Dependent Child or a Dependent Child's spouse. 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.

2. Prenatal ultrasounds are limited to two (2) routine ultrasounds per pregnancy. Additional ultrasounds are allowed if they are deemed Medically Necessary by the Physician due to a condition of risk to the mother or child.

3. The Policy will provide an adoption indemnity benefit payable to the Insured if a child is placed for adoption with the Insured within ninety (90) days of the child's birth. This benefit is subject to the Calendar Year Deductible and applicable co-insurance amount, and is limited to a maximum payment of $4,000. The Company will seek reimbursement of this Benefit if the post-placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.

L. **OFFICE VISITS:** Office Visits that are Medically Necessary are covered as set forth in the Schedule of Benefits.

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

1. Physician's professional and surgical services are covered.

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

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

4. X-rays, laboratory tests, pathological services, and machine diagnostic tests are covered.

5. Physical therapy that is rendered by a qualified licensed professional physical therapist is covered. Physical therapy must be prescribed by a Physician or a Physician's assistant as to the type and the duration. Physical therapy that is administered to the back and spine is only covered under the provision for back and spine manipulations and modalities.

6. Back and spine manipulations and modalities are covered.

7. Orthopedic braces are covered. Shoes or related supportive or corrective devices, including orthotics, are not covered.

8. Purchase or rental (up to the purchase price) of Durable Medical Equipment is covered. For the purpose of this Benefit, the term Durable Medical Equipment includes wheelchairs; hospital beds; home monitoring equipment; and similar mechanical equipment. There is no allowance for maintenance of any items purchased under this section.

9. Prosthetics for artificial limbs or eyes are covered. Only the initial prosthetic device is eligible for payment, unless the initial device is no longer serviceable and it cannot be made serviceable.

10. 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 who does not ordinarily reside in the Employee's home.

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

12. Cardiac rehabilitation therapy, such as, but not limited to, the use of common exercise equipment while under a Physician's care is covered. The therapy must take place in a formal rehabilitation program at an accredited facility, and must be prescribed by a Physician. Therapy must be rendered within ninety (90) days following cardiac Illness or surgery in order to be eligible.

13. The first lens purchased in conjunction with cataract surgery is covered as a Major Medical expense.

14. Prompt repair performed by a dentist to the extent such services are Medically Necessary by reason of damage to or loss of sound natural teeth due to Accidental Injury (other than from chewing); or for osteotomies, tumors, or cysts. Repair must be done within one (1) year of the Accidental Injury.

15. Circumcisions are covered as set forth in the Schedule of Benefits.

16. The Plan covers treatment for inborn errors of amino acid or urea cycle metabolism including medical services and dietary products. Dietary products means medical food or a low protein modified food product that: (i) is specifically formulated to treat inborn errors of amino acid or urea cycle metabolism; (ii) is not a natural food that is naturally low in protein; and (iii) is used under the direction of a Physician.

17. Reconstructive surgery and prosthetic devices incident to a covered mastectomy. For purposes of this section, the term "reconstructive surgery" shall mean a surgical procedure performed following a mastectomy on one breast or both

breasts to establish symmetry between the two breasts. The term includes but is not limited to, augmentation mammoplasty, reduction mammoplasty, and mastopexy.

18. Drugs and medicines that require a Prescription Order and that are prescribed for the condition(s) for which they are approved for use by the Food and Drug Administration ("FDA") are covered. Prescription Drugs purchased through the Prescription Drug Benefit apply to the Deductible and the Out-of-Pocket yearly maximum. An equivalent Generic Drug must be used whenever one is available. If a brand name drug is purchased instead of a generic equivalent, the Insured is responsible for the price difference. Prescribed, anticancer medications that are administered orally and that are used to kill or slow the growth of cancerous cells are paid as major medical expenses and are not paid as Prescription Drug Benefits. This Benefit includes medication prescribed as part of a clinical trial, which is not the subject of the trial. 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.

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

20. Therapy for pulmonary rehabilitation is covered while under a Physician's care. The therapy must take place in a formal rehabilitation program at an accredited facility and must be prescribed by a Physician. Therapy must be provided within the ninety (90) days following the diagnosis of pulmonary illness or surgery in order to be eligible.

21. Expenses for epidural injections for back pain are limited to three (3) per month and no more than six (6) per calendar year.

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

23. Diabetes self-management training and patient management, including medical nutrition therapy, when deemed medically necessary and prescribed by an attending physician.

24. Expenses for devices for contraception, including treatment or services rendered in connection with placement of such devices are covered. Expenses for Prescription Drugs for contraception are eligible for Benefits.

25. Prescription vitamins (including prenatal and pediatric vitamins), in single or in combination form; prescription calcium supplements; and prescription hematinics. Coverage is available for injectable and non-injectable forms.

26. Expenses are covered for the diagnosis of, and treatment of, autism spectrum disorders. Coverage includes the following:

    (a) Medically Necessary behavioral health treatment, including applied behavioral analysis, that is necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of the individual, and that is provided or supervised by a board certified behavior analyst or a licensed Provider whose scope of practice includes mental health services;
    (b) medications prescribed by a Physician;
    (c) psychiatric or psychological care; and
    (d) therapeutic care that is provided by licensed or certified speech therapists, occupational therapists or physical therapists.

    A health care Provider shall submit a treatment plan for autism spectrum disorder to the Company within fourteen (14) business days of starting treatment. The Company shall have the right to request a review of the treatment not more than once every three (3) months. A review may include a review of treatment goals and progress toward the treatment goals.

27. Emergency room services, supplies and treatment are covered. Emergency care, as defined in the Policy, that is rendered by a non-Preferred Provider will be reimbursed as though the Insured had been treated by a Preferred Provider.

28. Services related to Phase I, II, III or IV of an approved clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease are covered provided the services are otherwise eligible for Benefits under this Plan. Related services do not include: (1) the investigational item, device or service itself; (2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Insured; and (3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

VI. GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL BENEFITS:

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

1. Expenses for care or services provided before the Insured's Effective Date or after the termination date of the Insured’s coverage.

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

does not apply to an Owner who has elected the optional 24-hour coverage and has paid the applicable premium.

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

4. Expenses covered under automobile or vehicle medical payment provisions or under an automobile or vehicle No-Fault Insurance Act, or which would have been covered under No-Fault insurance coverage when the party is legally responsible for having No-Fault coverage in place. This exclusion applies whether or not the No-Fault coverage is actually in effect.

5. Expenses for any loss to which the contributing cause was the Insured's or Dependent's voluntary commission of, or attempt to, commit a felony, or to which a contributing cause was the Insured's being voluntarily engaged in an illegal occupation.

6. Care or treatment of an Accident, Illness or Injury caused by, or arising out of the following: voluntary participation in a riot; war; an act of war while in military, naval, or air services of any country at war, including but not limited to, declared or undeclared war; or acts of aggression voluntarily committed by a person entitled to Benefits.

7. Examinations, reports, or appearances that are in connection with legal proceedings.

8. Experimental or Investigational Treatments or Procedures. This exclusion also applies to any related services, supplies, or accommodations for these treatments or procedures.

9. Expenses in connection with transplants (except as specifically set forth in the Schedule of Benefits). This exclusion applies whether the Insured is the donor or the recipient.

10. Expenses for care, treatment or operations which are performed primarily for Cosmetic purposes and expenses for complications of such procedures. This exclusion does not apply when expenses are incurred as a result of an Injury, infection or other diseases of the Insured. This exclusion also does not apply when expenses are incurred for reconstructive surgery after a mastectomy, or for reconstructive surgery because of a congenital disease or anomaly of a Dependent Child that has resulted in a functional defect.

11. Expenses for treatment of obesity or for weight reduction. This exclusion includes, but is not limited to, stomach stapling; gastric bypass; balloon implant; other similar surgical procedure; and Prescription Drugs for the purpose of weight loss or weight control.

12. Expenses in connection with reversal of a gastric or intestinal bypass, balloon implant, gastric stapling, or other similar surgical procedure.

13. Expenses in connection with genetic studies, genetic testing, or genetic counseling.

14. Expenses for care or treatment of mental conditions that are not classified as Mental Illness as defined in the Policy are not covered. The diagnosis of Mental Illness must be made pursuant to a personal examination of the patient by a Provider duly licensed to make such diagnosis.

15. Expenses made which are in excess of Usual and Customary charges that are accepted as payment for the same service within a geographic area.

16. Care or treatment of marital or family problems; behavior disorder; chronic situational reactions; or social, occupational, religious or other social maladjustment, including drugs for the same.

17. Expenses for milieu therapy; modification of behavior; biofeedback; or sensitivity training.

18. Care or treatment of psychosexual identity disorder; transsexualism; sexual transformation; or psychosexual dysfunction. This exclusion does not operate to deny Mental Illness care related to such conditions, which is covered elsewhere in the Policy.

19. Care or treatment of learning disability; developmental disorder; intellectual disability; chronic organic brain syndrome; personality disorder; or for care or treatment of psychiatric or psychosocial conditions for which reasonable improvement cannot be expected. This exclusion does not apply to services required to diagnose any of the above.

20. Expenses for alleviation of chronic, intractable pain by a pain control center or under a pain control program to the extent those expenses exceed the Usual and Customary expenses for Semi-private room accommodations.

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

22. Expenses for reversal of surgically performed sterilization or resterilization.

23. Expenses for rest cures.

24. Expenses in connection with institutional care, which are, as determined by the Company, for the primary purpose of controlling or changing the environment of the Insured.

25. Expenses for facility charges at an Ambulatory Service Facility or a Hospital when the facility is not operating within the scope of their license.

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

27. Expenses for services incurred for intentional self-destruction or self-Injury or any attempt at self-destruction, unless the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

28. Expenses for an Illness or Injury resulting from the Insured's use or abuse of any illegal drug.

29. A loss directly related to the Insured's voluntary participation in an activity where the Insured: (a) is found guilty of an illegal activity in a criminal proceeding; or (b) is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty, a no contest plea, and a plea in abeyance.

30. Expenses for which the Insured, the Insured person, or his guardian is not legally obligated to pay.

31. Expenses associated with any service associated with pregnancy, unless the patient is the Insured Employee or the spouse of an Insured Employee. Notwithstanding this exclusion, eligible prenatal and postnatal preventive and wellness services that are associated with pregnancy for a Dependent Child are covered as set forth elsewhere in the Schedule of Benefits section of this Plan.

32. Expenses for any services or products unless the services or products were both:

    (a) Medically Necessary.

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

33. Expenses for training; educating; or counseling a patient. This exclusion does not apply when such services are incidentally provided (without a separate expense) in connection with other Covered Services. This exclusion also does not apply when the services are Medically Necessary and they are specifically prescribed by a Physician.

34. Expenses for a private school; public school; or halfway house.

35. Expenses associated with speech therapy. This exclusion does not apply when such services are required to restore to function speech loss or impediments due to Illness or Injury.

36. Expenses for transportation (except Medically Necessary ambulance services). This exclusion includes, but is not limited to, any of the following events:

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

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

(c) Ambulance services that do not go to the nearest facility that is expected to have appropriate services for the treatment of the Injury or Illness involved.

37. Expenses incurred for diagnostic purposes which are not related to an Injury or Illness unless they are otherwise provided for by the terms of the Plan or in the Schedule of Benefits.

38. Expenses for: (i) Routine Physical Examinations for Insureds which exceed the guidelines set forth in this Policy or the Schedule of Benefits; (ii) x-ray or laboratory procedures when there are no symptoms of Illness or Injury, unless they are covered as part of the Routine Physical Examination Benefit; or (iii) mental examinations or psychological tests when there are no symptoms of Mental Illness.

39. Expenses for preventative medical care (except as specifically set forth in the Schedule of Benefits).

40. Expenses for appointments scheduled and not kept.

41. Expenses for telephone consultations, whether they are initiated by the Insured or the Provider.

42. Expenses for the care and treatment of: teeth; gums; or alveolar process; dentures; dental appliances; or supplies used in such care and treatment except as specifically provided for by the terms of the Plan or in the Schedule of Benefits. Such expenses may be considered for Benefits under the Dental Policy if Dental coverage has been selected and premiums have been paid. This exclusion does not apply to the extent such care is eligible pursuant to the preventive and wellness services as set forth in the Schedule of Benefits.

43. Expenses in connection with Temporomandibular Joint Syndrome ("TMJ"); upper or lower jaw augmentation; reduction procedures (orthognathic surgery); or appliances or restorations necessary to increase vertical dimensions or restore occlusion, including, but not limited to, injection of the joints; prosthodontic treatment; full mouth rehabilitation; orthodontic treatment; bone resection; restorative treatment; splints; physical therapy; and bite guards.

    If surgical treatment for such procedures is deemed to be Medically Necessary and is in accordance with accepted medical practice as determined by the Company, Benefits will be allowed at **50%**. The treatment plan must be specifically authorized in writing by the Company prior to surgery.

44. Expenses for services incurred for the drainage of an intraoral alveolar abscess.

45. Expenses for charges incurred with respect to the eye for diagnostic procedures (including, but not limited to: eye refraction; the fitting of eyeglasses or contact lenses; and orthoptic evaluation or training). This exclusion does not apply to lens implants (either donor or artificial) for cataracts, or when required as part of an examination to diagnose an Illness or Injury (other than refractive errors of vision). Such expenses may be considered for Benefits under the Vision Policy if that coverage has been selected and premiums have been paid. This exclusion does not

apply to the extent such care is eligible pursuant to the preventive and wellness services as set forth in the Schedule of Benefits.

46. Expenses for surgery on the eye to improve refraction and treatment for refractive error of vision. This exclusion includes, but is not limited to radial keratotomy; orthokeratology; corneal carving; corneal slicing; and LASIK.

47. Expenses for hearing examinations; hearing aids; or the fitting of hearing aids; cochlear implants; or any devices used to aid or enable hearing. This exclusion does not apply when such services are required as part of an examination to diagnose an Illness or Injury.

48. Expenses for:

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

    (b) Casting for and fitting of supportive devices (including orthotics).

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

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

50. Expenses for services provided by the Insured's parent, Spouse, sibling or Child, including a step or in-law relationship.

51. Expenses for acupuncture or acupressure.

52. Expenses for radioallergosorbent ("RAST") testing.

53. Expenses for preventative medication (except as set forth elsewhere in the Plan), non-prescription vitamins, mineral and nutrient supplements, fluoride supplements, food supplements, sports therapy equipment, and the services and applications of such.

54. Expenses for anabolic steroids; weight-reduction drugs; growth hormones; and non-prescription hematinics.

55. Expenses for services, supplies, and treatment for hair loss, including, but not limited to, the use of minoxidil and Rogaine.

56. Expenses for experimental drugs; non-legend drugs; and anti-wrinkle agents. Tretinoin, all dosage forms (for example, Retin A) for Insureds over twenty-five (25)

years of age is eligible for Benefits if it is being used for a medical condition, and will be subject to preauthorization through the pharmacy benefit manager.

57. Medicines that, by a law of the United States, require a Physician's Prescription.

58. Expenses for autopsy procedures.

59. Expenses for artificial insemination; invitro fertilization; all procedures to preserve sperm and ova; Prescription Drugs and medications to induce fertility; gamete intrafallopian transfer ("GIFT"); and any other procedures designed to help or treat infertility.

60. Expenses for the care or treatment of elective surgery; complications of elective surgery; or complications of an ineligible procedure. Examples of such complications include, but are not limited to: 1) an infection resulting from a gastric bypass; 2) a ruptured implant after a breast augmentation; 3) an allergic reaction to an experimental drug; 4) complications of maternity for a dependent child; 5) flap displacement after a LASIK surgery.

61. Expenses for circumcisions that are not performed within thirty (30) days of birth or adoption.

62. Expenses for massage therapy.

63. All shipping, handling, delivery, sales tax, or postage charges, except as incidentally provided in connection with Covered Services or supplies.

64. Expenses for Occupational Therapy.

65. Expenses for an elective abortion, including any medications and Prescription Drugs that are for the purpose of causing abortion. An "elective abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

66. Expenses that are incurred as the result of the Insured or any insured person committing a fraudulent insurance act.

67. Care rendered outside of the United States, except Urgent Care or Emergency care.

68. Drugs and medicines that are available over the counter, or do not require a Prescription Drug Order.

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

70. Expenses for any losses resulting directly, in whole or in part, from the Insured operating any motorized vehicle, including watercraft, while exceeding the legal limit of intoxication in the jurisdiction where the Injury occurred. Violations that are subject to this exclusion will be established: (a) in a criminal proceeding in which the Insured is found guilty, enters a no contest plea or a plea in abeyance, or enters into a diversion agreement; or (b) upon the Company's request for an independent review where the findings support a decision to deny coverage. This exclusion does not apply to an Insured who is under eighteen (18) years of age.

VII. COBRA, USERRA, AND EXTENSION OF BENEFITS:

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 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.
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. **Extension of Benefits:**

1. An individual whose insurance under the group Policy has been terminated, and who has been continuously insured under the group Policy for at least three (3) months prior to termination, has the right to continue coverage under the group Policy for a period of twelve (12) months, unless the Employee (i) was terminated for gross misconduct; or (ii) is eligible for an extension of coverage required by federal law. When applicable, any extension of coverage required by federal law may run concurrently with the requirements of this section. This right to continue coverage includes any Dependent coverage.

   The Employer shall provide the Insured written notification of the right to continue group coverage and the payment amounts required for continued coverage, including the manner, place, and time in which the payment shall be made. This notice shall be given not more than thirty (30) days after the termination date of the group coverage. The notice may be sent to the terminated Insured's home address as shown on the records of the Employer.

   The payment amount for continued group coverage may not exceed the group rate in effect for group member, including the Employer's contribution, if any, for a group insurance Policy, or the amount specified by federal law, whichever is applicable.

   If the terminated Insured, or with respect to a minor, the parent or guardian of the terminated Insured elects to continue group coverage and tenders to the Employer the amount required within sixty (60) days after the date of termination of the group coverage, coverage of the terminated Insured and coverage of the covered spouse and Dependents of the terminated Insured continues without interruption and may not terminate unless:

(a) The terminated Insured establishes residence outside of this state;

(b) The terminated Insured fails to make timely payment of a required contribution;

(c) The terminated Insured violates a material condition of the contract;

(d) The terminated Insured becomes eligible for similar coverage under another group Policy; or

(e) The Employer's coverage is terminated.

If the Employer replaces coverage with similar coverage under another group Policy, without interruption, the terminated Insured has the right to obtain coverage under the replacement group Policy for the balance of the period the terminated Insured would have continued coverage under the replaced group Policy, provided the terminated Insured is otherwise eligible for continuation of coverage.

VIII. 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) An individual health insurance plan; a group accident and health insurance plan; uninsured arrangements of group or group-type coverage; coverage through closed panel plans; medical care components of long-term care contracts, such as skilled nursing care. This also includes coverage for students other than school accident-type coverage; or

   (b) Coverage under a governmental plan or 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), such as an employee, member, policyholder, retiree or subscriber, 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 married or living together if they have never been married, 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)(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 or are not living together if they have never been married, the following rules apply:

   i) If a court decree states that one of the parent's is responsible for the Child(ren)'s health care expenses or health care coverage, the responsible parent's plan is the primary plan.
   ii) If the parent with responsibility has no health care coverage for the Child(ren)'s health care expenses, but the spouse of the responsible parent does have health care coverage for the Child(ren)'s health care expenses, the responsible parent's spouse's plan is the primary plan.
   iii) If a court decree states that both parent are responsible for the Child(ren)'s health care expenses or health care coverage, the provisions of section 2(c)(2) above shall determine the order of benefits.
   iv) If a court decree states that the parent's have joint custody without stating that one parent has responsibility for the health care expenses or health care coverage of the Child(ren) the provisions of section 2(c)(2) above shall determine the order of benefits.

v) If there is no court decree allocating responsibility for the Child(ren)'s health care expenses or health care coverage, the order of benefits are determined as follows:

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);

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

d. Then by the health care plan of the spouse of the parent not having custody of the Child(ren).

vi) For a Child(ren) covered under more than one plan, and one or more of the plans provides coverage for individuals who are not the parent of the Child(ren), such as a guardian, the order of benefits shall be determined under the provisions of section 2(c)(2) or section 3 above, as if those individuals were the parents of the Child(ren).

4. The benefits of a plan, which covers a person as an active employee who is neither laid off or retired, or as a dependent of an active employee, are determined before those of a plan which cover that person as a retired or laid off employee. 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 section does not apply if the rule in section 2(c)(1) can determine the order of benefits.

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 persons it has paid or for whom it has paid, insurance companies, or other organizations.

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

B. **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: The Company shall be entitled to the proceeds of any settlement or judgment which results in a recovery from the third party. This recovery shall be up to the amount of Benefits paid for the Illness or Injury. This recovery shall apply 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 collecting from the third party.

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

C. **PERSONS COVERED BY MEDICARE:**

1. This Plan will pay its Benefits before Medicare for any of the following:

(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 for both of the following:

   (a) For all other Insured persons.

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

IX. GENERAL POLICY INFORMATION:

A. **COMPUTATION OF EMPLOYER PREMIUMS:** The initial premium due and each subsequent premium due shall be the sum of both of the following calculations:

1. The number of Insured Employees in each classification multiplied by the applicable rate for each person.

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

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

1. On the Plan's renewal date. The Company will give written notice to the group Policyholder at least thirty-one (31) days prior to such premium due date.

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

Premiums may also be computed by any method mutually agreeable to the Company and the Policyholder. Any alternative method must produce the same total amount as the above methods.

B. **PAYMENT OF PREMIUMS:** All premiums that are due under this Plan, and any adjustments, are payable by the Policyholder on or before their respective due dates, 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. The Plan remains in force during

such grace period. If payment is not received before the grace period expires, the Plan will be terminated as of the last day of the grace period.

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. The Policyholder shall be liable to the Company for the payment of all premiums then due and unpaid, including a pro rata premium for the grace period. If the Policyholder gives written notice to the Company that this Plan is to be terminated before the end of the grace period, this Plan shall be terminated on the later of the date of receipt of such notice, or the date specified by the Policyholder. The Policyholder shall be liable to the Company for the payment of all premiums 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.

The Policyholder is obligated to notify each insured Employee, in writing, 30 days prior to the date of Policy termination, that group coverage is being terminated, and of the right to continue coverage.

E. **RECORD OF EMPLOYEES INSURED:** The Company shall maintain a record which shall show at all times the names of all Insured Employees, the beneficiary designated by each Employee, if any, the date when each Employee became insured and the Effective Date of any change in coverage. This record shall also show any other information that may be required to administer the insurance. The Company shall furnish a copy of this record to the Policyholder, upon request. The Policyholder shall give the Company any information that is required for administering the insurance. This information shall include, but is not limited to, information for enrolling Employees, changes in coverage, and termination of insurance. Any records of the Employer and/or Policyholder that may have a bearing on this insurance shall be open for inspection by the Company at a reasonable time.

F. **EMPLOYEE'S CERTIFICATE:** The Employer is the Plan Administrator as that term is defined in the Employee Retirement Income Securities Act ("ERISA"), 29 U.S.C. §§ 1001 *et. seq.* The Company will issue Certificates to the Policyholder to deliver to each individual Insured Employee. The Certificate may also be delivered directly to the Insured Employee. The Certificates shall describe the Policy Benefits and to whom the Benefits will be paid. The Certificates shall also describe any Policy limitations or requirements that effect the Insured Employee. The word "Certificate" as used in this Plan shall include all applicable Schedules of Benefits, and any riders and supplements. Such Certificates are a summary of the Plan only and shall not constitute a part of, or amendment to, this Plan. If the provisions of this Plan and the Certificates of insurance conflict, the terms of this Plan shall govern.

G. **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.

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.

Pre-Service Urgent Care Claim

Pre-certification for pre-service claims that involve Urgent Care is **not** required, although it is recommended. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. If Pre-certification is performed for a pre-service claim that involves Urgent Care, the benefit determination will be made within seventy-two (72) hours. If a request for an Urgent Care pre-service claim that fails to meet the filing procedures is received or is incomplete, notice will be sent to the Insured regarding the proper procedures to be followed for filing a request. This notice will be provided as soon as possible but no later than twenty-four (24) hours after the receipt of the request. The Insured will be given at least forty-eight (48) hours to provide the necessary information. A benefit determination will be provided within forty-eight (48) hours after receiving the necessary information.

Concurrent Care Claim

For concurrent review requests involving a request by the Insured to extend the course of treatment beyond the initial period of time or treatments, a determination will be made no later than twenty-four (24) hours after the date of receiving the request, as long as the request was filed at least twenty-four (24) hours prior to the expiration of the approved period of time or number of treatments. If the request for extension does not involve Urgent Care, the Company must notify the Insured of the benefit decision using the response times for a post-service claim. An ongoing course of treatment for which Pre-certification has been received may not be subsequently reduced or terminated unless written notice is provided to the Insured sufficiently in advance to allow the Insured to appeal the determination and obtain a decision prior to the reduction or termination.

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

The Plan provides three levels of appeal review, which may be performed either internally or independently, as described herein. The first two levels are required levels that must be exhausted before an Insured can file suit in court. The third level is a voluntary level. 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. 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 first and second level 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.

Independent, External Review for First and Second Level Appeals - 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").

Third Level Appeal – An Insured also has a right to a third appeal level known as an external independent review level. This level is available once the internal appeals process is exhausted, or if the Plan has exceeded the timelines for appeal response without good cause and without reaching a decision. The external review level can only be used for adverse benefit determinations that are based on medical necessity, appropriateness, health care setting, level of care, or the effectiveness of the health care service or treatment you requested, including for an adverse benefit determination that involves consideration of whether the Plan has complied with the surprise billing and cost-sharing protections of the No Surprises Act. This review level can also be used for adverse benefit determinations for services that are experimental or are investigational. When filing a request for an external review, the Insured is required to authorize the release of any medical records that may be required for the purpose of reaching a decision on the external review. To receive additional information regarding an independent external review, the Insured may contact the Utah Insurance Commissioner by mail at 4315 S. 2700 W., Ste. 2300, Taylorsville, UT 84129; by phone at (801) 957-9280; or electronically at healthappeals.uid@utah.gov.

Standard External Independent Review: If an Insured receives an adverse benefit determination on the second level of appeal, and the appeal qualifies for external independent review, he may submit a written request for review within 180 days from the receipt of the determination notification, along with any additional applicable information, to the Utah Insurance Commissioner. The appeal will be reviewed by an Independent Review Organization ("IRO") assigned by the state. The Insured and the treating provider will be notified in writing of the IRO's decision within forty-five (45) days after receipt of the request for review. There will be no fee charged to the Insured for an independent review.

Expedited External Independent Review: An Insured may request an expedited external independent review if the final internal adverse benefit determination (i) 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; (ii) in the opinion of the Insured's attesting provider, would subject the Insured to severe pain that cannon be adequately managed without the care or treatment that is the subject of the adverse benefit determination; or (iii) involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the Insured or jeopardize the Insured's ability to regain maximum function. The appeal will be reviewed by an Independent Review Organization ("IRO") assigned by the state. The IRO must make its decision to uphold or reverse the final internal adverse benefit determination and notify the Insured and the Company as expeditiously as possible but no later than seventy-two (72) hours after it receives the request for expedited review.

External Independent Review for Issues Involving an Experimental or Investigational Service or Treatment: A request for an external independent review based on experimental or investigational treatment shall be submitted with a certification from the Insured's Physician that: (i) standard health care service or treatment has not been effective in improving the Insured's condition; (ii) standard health care service or treatment is not medically appropriate for the Insured; or (iii) there is no available standard health care service or treatment covered by the Plan that is more beneficial than the recommended or requested health care service or treatment. The appeal will be reviewed by an Independent Review Organization ("IRO") assigned by the state. The IRO shall select one or more clinical reviewers to conduct the review. The clinical reviewer shall provide to the IRO a written opinion within 20 days for a standard review and within five days for an expedited review. The IRO shall make a decision based on the clinical reviewer's opinion within 20 days for a standard review and within 48 hours for an expedited review.

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 is defined as the amount of earnings in excess of earnings required to maintain the highest Risk-Based Capital ("RBC") level established by law and the amount required to maintain and appropriate level of financial reserve as determined by the Board of Directors in its sole discretion. Earnings is defined as the excess of earned revenue over incurred Benefits and expenses using statutory accounting methods prescribed or permitted by law.

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 Policyholders, such earnings will be refunded 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 refund, a participating Employer must be a Policyholder at the time the refund is made.

J. **NON-ASSESSABLE PLAN:** This Plan is non-assessable. 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. No such statement may be a basis for avoidance of a policy, coverage, or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two (2) years.

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 or immediately if such change is necessary in order to conform to changes in the HAS and HDHP laws. The Plan may be amended by written agreement between the Policyholder and the Company without the consent of the Insured Employees or their beneficiaries. This Plan may also be amended on the Plan's renewal date upon sixty (60) days written notice from the Company to the Policyholder. If an Insured is confined in a Hospital or Extended Care Facility on the effective date of the amendment, Benefits shall not be affected until the date of discharge. No change in the Plan shall be valid until 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. The notice must have sufficient information to be able to identify the Insured Employee or the Insured Dependent. Notice given to any authorized agent of the Company shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in the Plan shall not invalidate any claim if it is shown that it was not reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

The Company, upon receipt of the notice required by the Plan, will furnish to the claimant such forms as are usually furnished by the Company for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the Company receives such notice, the claimant shall be deemed to have complied with the requirements of the Plan of filing proof of loss, 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. Such examinations will be paid by the Company.

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, medical records relating to care and treatment of any Insured who claims Benefits under this Plan, prior to paying any Benefits under this Plan. The Insured does fully authorize, empower, and direct his Provider to furnish the Company with such complete reports and medical records when he requests any Benefits.

R. **OVERPAYMENTS:** If for any reason the Company pays any amount to, or on behalf of, the Insured for (i) services not covered under this Plan; (ii) services which exceed amounts to be paid as Benefits under this Plan; or (iii) services on behalf of a person believed to be a Dependent who is not covered under this Plan, the Company may, at its discretion, recover overpayments from one or more of the persons it has paid or for whom it has paid. The Company may also recover overpayments from future claim payments made to the same provider for services that are rendered to the same Insured.

The time limits listed below apply for requesting overpayments.

1. At any time in the event a fraudulent insurance act is committed.
2. Within twenty-four (24) months for amounts that were improperly paid for a coordination of benefits error.
3. Within twelve (12) months for amounts that were improperly paid for any other reason not specific above.
4. Within thirty-six (36) months for amounts that were improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program.

S. **LEGAL PROCEEDINGS:** No action of law or in equity shall be brought to recover on the Plan until the earlier of: (i) sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan; (ii) waiver by the Company of proof

of loss; or (iii) the Company's denial of full payment, 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, furnishing proof of loss, or bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Policy is delivered, such limitation shall be extended to agree with the minimum period permitted by such law.

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.

V. **SUPERSEDED PLAN:** If this Plan supersedes a health care Plan previously issued by the Company, Benefits furnished under the previous Plan shall apply to the maximums of this Plan as though such Benefits had been furnished under this Plan.

W. **PREFERRED PROVIDER ORGANIZATION ("PPO"):** If you obtain services from a preferred provider, eligible Benefits will be processed according to the preferred provider discounted rate, and will be reimbursed at a higher percentage level. A directory of PPO providers is available from the Company, free of charge. You may also obtain services from a non-preferred provider, however, eligible Benefits will be processed according to the usual, reasonable and customary rate and will be reimbursed at a lower percentage level.

The Company will process claims for covered health care services received from a non-preferred independent hospital, a credentialed staff member at an independent hospital, a credentialed staff member at his local practice, or a federally qualified health center at the preferred provider coinsurance level if the enrollee: (i) lives or resides within 30 paved road miles of such provider; or (ii) lives or resides in closer proximity to such provider than a preferred provider. In addition, if there is a lack of a specific type of preferred provider within 30 miles of an insured's residence, and an insured must travel more than 30 miles to reach a preferred provider who is qualified to provide the specific service that is needed, the service may be obtained from the closest appropriate non-preferred provider who is qualified to provide the service, and claims will be processed at the preferred provider coinsurance level.

No Surprises Act Provisions

If an Insured receives Emergency services at a non-PPO facility, receives Emergency services at a PPO facility but by a non-PPO Provider within such facility, or receives Eligible Charges for air Ambulance services from a non-PPO provider, Benefits will be processed at the PPO cost sharing level. The Insured will only be responsible for the PPO cost sharing amounts. The Provider may not balance bill the Insured for any

amounts above the PPO cost sharing level. This includes post-stabilization services, unless you give written consent and give up your protections to not be balance billed for such services.

The above provision also applies if an Insured receives non-Emergency services at a PPO facility but by a non-PPO Provider within such facility. However, if an Insured receives a notice from the Provider prior to services being rendered that states that the Provider is a non-PPO Provider and that contains a good faith estimate of the amount that will be charged, and the Insured voluntarily agrees to receive such care, the Benefit protections set forth above will be waived. Notwithstanding this provision, such protections cannot be waived if there is no PPO provider available, for Urgent Care, or for services rendered by certain types of Providers as determined by federal law.

If an Insured is receiving treatment from a Preferred Provider whose contract is terminated during the course of the treatment for a reason other than for fraud or for failure to meet quality standards, the Insured may continue to obtain treatment from such Provider if the Insured is undergoing a course of treatment for: (1) an acute Illness that requires specialized treatment to avoid the reasonable possibility of death or permanent harm; or (2) a chronic Illness which is life-threatening, degenerative; potentially disabling or congenital, and which requires specialized medical care over a prolonged period of time. Benefits for such treatment will be processed at the PPO cost sharing level. Such coverage must be provided until the earlier of: (1) 90 days; or (2) the date the Insured no longer requires such continuing care.

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.

X. PRIVACY POLICY

We at WMI Mutual Insurance Company respect the privacy of your protected health information ("PHI"). We only use and disclose this type of information as permitted by law, in order to provide you with quality service and to administer our business functions. We do not use or disclose your information outside of the exceptions allowed by law.

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

- **Disclosure of Information.** We may disclose your personal information to agents, health care providers, or service providers that perform business functions on our behalf. Examples of these types of functions are claims processing and utilization management. We obtain assurances from our service providers that they will also protect the privacy of your information. Personal information regarding a spouse or dependent children will also be disclosed to the insured employee (or the insured former employee) in the form of an explanation of benefits when a claim is processed. We will not disclose your PHI outside of our normal business functions unless we first obtain a written authorization from you.

- **Security.** We maintain procedural, physical and electronic safeguards to protect the confidentiality of your personal information. Access to personal information is restricted to only those employees and service providers who need this information in order to provide products and services to you.

- **Individual rights.** You have the right to request restrictions on the uses and disclosures of your PHI, however, we are not required to agree to such restrictions. You have the right to inspect and copy your PHI and to request that corrections be made to such information. You have a right to an accounting of any disclosures that are made outside of the exceptions that are allowed by law.

- **Complaint procedure.** If you believe that your privacy rights have been violated, you may file a written complaint with WMI, or with the Office of Civil Rights, Region VIII, U.S. Department of Health and Human Services, 1961 Stout Street, Room 1185 FOB, Denver, CO 80294-3538. The complaint must describe the violation that occurred, and must be filed within 180 days of the known date of violation. You will not be retaliated against for filing a complaint.

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