



**WESTERN MUTUAL
INSURANCE® COMPANY**

**WASHINGTON GROUP HEALTH INSURANCE PLAN
CERTIFICATE BOOKLET**

1500 (60/40) Plan

Western Mutual Insurance® Company

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Western Mutual Insurance Company

(“The Company”)

Certifies that it has issued a group policy of
insurance to:

Western Petroleum Marketers Association

The Employee, and his eligible Dependents, is insured hereunder, subject to all of the provisions and limitations of said group policy.

This booklet is your Certificate of insurance. It describes the insurance protection to which you are entitled, but it does not constitute the group policy which has been issued to the Policyholder. This booklet contains the extent of the Company’s liability or obligation. No agent, person, or representative may vary the terms of the Certificate. The terms of the Policy may be changed. The insurance provided under the group policy is not in lieu of and does not affect the requirements for coverage under workers’ compensation insurance.

All Benefits are paid according to the terms of the group policy, a copy of which is on file with the Policyholder. In the event there is a conflict between the policy language and the Certificate language, the language in the Certificate will prevail.

All defined terms begin with capital letters.

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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 and Family Annual Deductible:

(a) Annual Deductible (Per Person):

1500 Plan: \$1500

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

(2) The Individual Annual Deductible amount applies separately to the Insured and each covered Dependent. The individual deductible will be waived for any family member during any Calendar Year in which the Family Deductible amount as set forth in this Schedule of Benefits has been satisfied.

(b) **Annual Maximum Family Deductible:** The Annual Maximum Family Deductible is equal to two (2) times the individual Deductible amount. Once the Annual Maximum Family Deductible is satisfied in any Calendar Year, the Individual Deductible is waived for all remaining family members for that Calendar Year.

2. Percentage of Eligible Charges payable after satisfaction of Deductible and prior to the satisfaction of the Out-of-Pocket maximum amounts for Inpatient Facility Services, Outpatient Hospital, Surgical Services, Medical Services and Services for Mental Illness:

(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): **40%**

(c) Pre-Deductible Benefit For Eligible Charges For All Covered Medical Services:

All medical services covered under this Policy (except for Prescription Drugs that are covered elsewhere in the Policy under the optional Prescription Drug card rider) 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. Amounts paid by the Insured for services for organ transplants and implants also do not apply toward the satisfaction of the Out-of-Pocket amounts.

(d) Routine Physical Examinations, Check-ups, and Immunizations:

(1) Well Baby Care (**these services are never subject to the Calendar Year Deductible, even if the \$500 maximum Benefit for pre-Deductible procedures has been met**): Office visits for routine check-ups for children during the first two years of life:

Inside PPO Network: 80%

Outside PPO Network: 60%

(2) Child Care: For children ages two (2) through and including age eighteen (18), the Policy covers one (1) office visit per Calendar Year for routine check-ups:

Inside PPO Network: 60%

Outside PPO Network: 40%

(3) For Insureds and Dependents age nineteen (19) or older, the Plan covers routine physical examinations and check-ups, including routine lab work required for the routine physical examination, to an annual maximum of **\$500**. This Benefit does not include mammograms, influenza immunizations, and prostate cancer screening, which are covered elsewhere in the Policy. Routine adult immunizations are covered for Insureds and Dependents age nineteen (19) or older as determined in accordance with the most recent guidelines of the Centers for Disease Control. Amounts in excess of the \$500 maximum are neither payable by the Company nor applicable to the Deductible.

Inside PPO Network: 60%

Outside PPO Network: 40%

- (4) Routine childhood immunizations, as determined in accordance with the most recent guidelines of the Centers for Disease Control:

Inside PPO Network: 80%

Outside PPO Network: 60%

- (5) Influenza immunizations:

Inside PPO Network: 80%

Outside PPO Network: 60%

(e) 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 and Preexisting Condition sections. 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 the invoice cost, plus 50%, 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 to a maximum payment amount of **\$20,000** per organ, 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 as defined in the Policy are deemed to be Preexisting Conditions unless sufficient documentation is produced to indicate otherwise. Category II organ transplants are only considered for benefits after the eligible Employee or Dependent has been insured under the Plan for a period of three (3) consecutive months. This waiting period, which applies regardless of whether the condition is a Preexisting Condition, shall be reduced by the number of days of Creditable Coverage calculated as of the Enrollment Date of the patient. 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. All pre-authorized Category II organ transplants are paid to a lifetime maximum payment of **\$350,000** per organ. The lifetime maximum payment shall apply from the date of Hospital admission, or from one day prior to the date of the transplant for a patient who receives a transplant during the

course of a longer Hospital stay, through one-hundred (100) days after the transplant. If an Insured receives an organ transplant while already in the Hospital for another chronic condition, only those charges that are specifically related to the organ transplant will be applied to the lifetime maximum transplant benefit. For the purpose of this Benefit, any transplant therapy or protocol involving bone marrow shall constitute one organ even if multiple transplants are performed. This maximum 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 to a maximum payment amount of **\$20,000** per organ, 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. The maximum amount payable for eligible donor charges will be applied to the lifetime maximum amount payable for the transplant.

(f) **Implantable Hardware:** The maximum allowable amount for Implantable Hardware, as defined in the Policy, is limited to the invoice cost, plus 50%. An invoice showing the actual cost of the implant must be submitted to the Company. The paid amount for Implantable Hardware that is used in conjunction with a joint implant will be applied to the lifetime maximum payment amount for the implant.

(g) **Ambulance services:**

Inside PPO Network: 60%
Outside PPO Network: 40%

(1) Ambulance service is limited to **\$2,500** per occurrence.

(2) Air Ambulance service is limited to **\$15,000** per occurrence.

(h) **Durable Medical Equipment:** Except as set forth below, eligible expenses are paid at **50%** not to exceed a maximum payment of **\$3,000** per Calendar Year, 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%** not to exceed a maximum payment of

\$7,500 per Calendar Year. This limit applies regardless of whether the pumps are internal or external.

2. Eligible expenses for equipment that is used for the treatment of diabetes (such as insulin pumps), equipment that is used for Home Health Care or Hospice care, and pacemakers are not subject to the limits as set forth above and are paid at the levels as for any other major medical expense.

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

Inside PPO Network: 60%
Outside PPO Network: 40%

- (j) **Prosthetics:** For a natural limb or eye which is lost while insured, only the initial prosthesis is eligible for payment at **50%** to a maximum payable amount of **\$5,000**. **Note:** Prosthetics that are provided as part of a mastectomy or breast reconstruction procedure are not subject to this limited benefit but are subject to the same terms and conditions applicable to all other covered Benefits within the Policy.

- (k) **Mammograms:** Subject to the following guidelines, mammograms are payable at:

Inside PPO Network: 60%
Outside PPO Network: 40%

- (1) A baseline mammogram for women between the ages of 35 and 40;
 - (2) An annual mammogram for women 40 years of age or older.
 - (3) A mammogram for any woman desiring a mammogram for medical cause.
- (l) **Circumcisions** performed within thirty (30) days of birth or adoption are covered up to a maximum of **\$150**.
- (m) **Prostate Cancer Screening:** Expenses must be recommended by the Insured's Physician or Practitioner:

Inside PPO Network: 60%
Outside PPO Network: 40%

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

(o) **Treatment for sleep apnea.** Eligible expenses 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.

(p) **Office Visits:**

Inside PPO Network: 60%

Outside PPO Network: 40%

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

Inside PPO Network: 60%

Outside PPO Network: 40%

(r) **Treatment for craniomandibular and temporomandibular joint disorders:** Eligible expenses for diagnostic, therapeutic, surgical and nonsurgical treatment, including, but not limited to, examinations, x-rays, injection of the joints, and splints. Eligible expenses are covered to a maximum Benefit of **\$1,000** per Calendar Year and a maximum lifetime Benefit of **\$5,000**. Pre-certification requirements **do not** apply if services are rendered due to an Accidental Injury and treatment begins within forty-eight (48) hours of the Accident.

Inside PPO Network: 60%

Outside PPO Network: 40%

(s) **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. Benefits shall be provided for individuals with insulin-using diabetes, with non-insulin using diabetes, and with elevated blood glucose levels induced by pregnancy.

Inside PPO Network: 60%

Outside PPO Network: 40%

(t) **Colonoscopy:**

Inside PPO Network: 60%

Outside PPO Network: 40%

Subject to the following guidelines in accordance with the American Cancer Society:

1. Once every ten (10) years beginning at age 50.
2. Once every five (5) years beginning at age 40 if colorectal cancer or adenomatous polyps were present in any first-degree relative (parent,

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

3. As frequently as is determined to be Medically Necessary for follow-up colonoscopies due to the presence of colorectal cancer or adenomatous polyps.
4. For Medically Necessary reasons at any age to diagnose a medical condition.

(u) Colorectal cancer screening tests:

Inside PPO Network: 60%
Outside PPO Network: 40%

Subject to the following guidelines in accordance with the United States Preventive Services Task Force and beginning at age 50 for a person at average risk (under age 50 for a person at high or very high risk):

1. A fecal occult blood test once every year; OR
2. A flexible sigmoidoscopy once every five (5) years; OR
3. A fecal occult blood test once every year plus a flexible sigmoidoscopy once every five (5) years; OR
4. A double-contrast barium enema every five (5) years; OR
5. A colonoscopy once every ten (10) years. For a person at higher risk, Benefits for a colonoscopy are available more frequently as described elsewhere in the Schedule of Benefits

3. Annual Out-of Pocket:

(a) Individual Annual Maximum Out-of-Pocket Payout:

1500 Plan: \$3,000

- (1) Except as set forth in this Schedule of Benefits or in the Policy, eligible charges will be paid at **100%** by the Company during any Calendar Year in which the applicable Out-of-Pocket amounts have been satisfied. Only Deductible and co-insurance amounts (except co-insurance amounts paid towards Prescription Drugs and amounts paid for any Benefits which are not eligible to be paid at 100%) that are incurred by the insured 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 optional Prescription Drug card rider, if the optional Prescription Drug card rider has been elected and premiums have been paid, regardless of whether the Individual Annual Maximum Out-of-Pocket amount has been satisfied.

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

1500 Plan: \$6,000

No individual family member may contribute more than one-half of the family Out-of-Pocket maximum and each family member must satisfy an individual Deductible amount (unless the Family Deductible has been satisfied) even if the annual family Out-of-Pocket maximum amount has been satisfied. Only Deductible and co-insurance amounts (except co-insurance amounts paid towards Prescription Drugs and amounts paid for any Benefits which are not eligible to be paid at 100%) that are paid by the Insured or Dependent during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Amounts paid for non-covered care or treatment do not apply toward the Out-of-Pocket maximums. Benefits for Prescription Drugs will always be paid in accordance with the optional Prescription Drug card rider, if the optional Prescription Drug card rider has been elected and premiums have been paid, regardless of whether the Individual Annual Maximum Out-of-Pocket amount has been satisfied.

4. Maximum Lifetime Benefit (per insured): \$2,000,000

B. OPTIONAL PRESCRIPTION DRUG CARD RIDER:

There is no Prescription Drug Benefit unless the optional Prescription Drug Card Rider has been elected and premiums have been paid. The Prescription Drug Deductible is a separate Deductible and cannot be used to satisfy the medical Deductible or medical Out-of-Pocket amounts. If the optional Prescription Drug Card Rider has been elected and premiums have been paid, drugs that are available for purchase through a retail pharmacy, but that are not purchased through the Prescription Drug Card Benefit, will be paid in accordance with the Prescription Drug Card Benefit and not as a major medical expense. They will also be limited to the maximum allowable cost, less any available discounts, that would have been available had the drugs been purchased through the Prescription Drug Card Benefit. If the optional Prescription Drug Card Rider has been elected, 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, including the Preexisting Condition limitation, apply to this Benefit. Expenses related to diabetes, including insulin, testing supplies, and syringes, are paid as a major medical expense as set forth in the Schedule of Benefits and not as a Prescription Drug Benefit. The Company is entitled to any and all available rebates that are paid by Prescription Drug manufacturers.

1. Deductible Per Person:

1500 Plan: \$250

2. Prescription Drug Co-Pay:

Generic: \$10 or 25% (whichever is greater*)

Brand: \$50 or 50% (whichever is greater*)

*In no event will the co-payment amount exceed the prescription drug purchase price.

3. Annual Prescription Drug Maximum: 1500 Plan: \$50,000

C. MENTAL ILLNESS CARE, TREATMENT OF CHEMICAL DEPENDENCY, AND DETOXIFICATION SERVICES (for Employers with 2-50 Employees):

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: 40%

2) Inpatient and Outpatient Treatment of Chemical Dependency: Eligible expenses are covered to a maximum of **\$15,000** in a consecutive twenty-four (24) month period.

Inside PPO Network: 60%

Outside PPO Network: 40%

- 3) **Detoxification Services:** Eligible expenses for detoxification services for Chemical Dependency are covered under the Emergency care provisions of the Policy. Pre-certification is not required for detoxification services.

D. MENTAL ILLNESS CARE, TREATMENT OF CHEMICAL DEPENDENCY, AND DETOXIFICATION SERVICES (for Employers with 51 or more Employees):

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: 40%

2. **Inpatient and Outpatient Treatment Chemical Dependency:**

Inside PPO Network: 60%
Outside PPO Network: 40%

3. **Detoxification Services:** Eligible expenses for detoxification services for Chemical Dependency are covered under the Emergency care provisions of the Policy. Pre-certification is not required for detoxification services.

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.

“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.

“Chemical Dependency” means a chronic illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under

Washington law and/or on alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

“Chemical Dependency Treatment Facility” means a treatment facility that is licensed by the state and that provides Inpatient and outpatient services as part of an “approved treatment program.” An approved treatment program means a treatment program that is certified by the Department of Social and Health Services as meeting the standards according to the Washington Insurance Code.

“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 Western Mutual Insurance Company.

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

“Complications of Pregnancy” means Illnesses whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy. Examples are acute nephritis, nephrosis, cardiac decompensation, spontaneous miscarriage, ectopic pregnancy, hydatidiform mole/molar pregnancy, eclampsia, pre-eclampsia and toxemia. Complications of Pregnancy do not include false labor, occasional spotting, physician prescribed bed rest, and morning sickness.

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

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

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

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

“Creditable Coverage” means Plan participants will be given “credit” toward the satisfaction of any Preexisting Condition Limitation period for the length of coverage under any of the following plans: (a) group health insurance; (b) Individual health insurance; (c) Medicare and Medicaid; and (d) Government programs such as, public

health plans, state high risk pools, or military plans. The exclusion for Preexisting Conditions will be reduced by the number of months that the Employee has remained covered under any of these plans. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the Enrollment Date, there was a period of ninety (90) days or more during all of which the individual was not covered under any Creditable Coverage. This ninety (90) day period shall not include any period that an individual is in a Waiting Period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period.

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

- (a) Do not provide treatment of an Injury or Illness; 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 cash amount of eligible charges paid per Insured person before insurance Benefits are paid.

“Dependent(s)” includes any of the following:

- (a) The Spouse of an Insured Employee.
- (b) The Insured Employee’s (or the Insured Employee’s Spouse’s) unmarried Child(ren), under twenty-five (25) years of age; and
- (c) A Child who has reached the limiting age for termination of coverage, but who is disabled and dependent upon the Insured, provided that the Child was enrolled in this Plan at the time of reaching the limiting age.

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

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

- (a) It is intended only for the patient's use and benefit in the care and treatment of an Illness or Injury.
- (b) It is durable and usable over an extended period of time.
- (c) It is primarily and customarily used for a medical purpose.
- (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.

“Emergency” means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

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

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

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

“Experimental or Investigational Treatment or Procedures” means medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical

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

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

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

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

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

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

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

- (a) Is engaged in providing nursing services and other medical services under the supervision of a Physician;
- (b) Maintains a complete medical record on each patient;

- (c) Is not engaged in providing Custodial Care, care or treatment of Mental Illness, or care or treatment for drug or alcohol abuse or dependency; and
- (d) Qualifies as a reimbursable service under Medicare.

“Hospital” means a facility which is licensed and accredited by the Joint Commission on Accreditation of Hospitals (“JCAH”) which operates within the scope of such license, and which makes use of at least clinical, laboratory, diagnostic x-ray services, and major surgical facilities.

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

“Illness” means a bodily disorder 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.

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

“Maximum Lifetime Benefit” means the maximum benefit payable by WMI to any insured individual during their lifetime regardless of the named policyholder. This

includes any amounts payable pursuant to COBRA, state extension of benefits, and conversion provisions. For conversion provisions, benefits payable during the first year of the conversion policy, together with the benefits paid for the individual under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force.

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

“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 mental retardation.

“Occupational Therapy” means the use of any occupation or creative activity for remedial purposes to retrain the patient in work activities (school, home management, and employment). Occupational Therapy is directed toward the coordination of finer,

more delicate movements than Rehabilitation/Physical Therapy, such as coordination of fingers, to the sick or injured person's highest attainable skills.

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

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

“Out-of-Pocket” means the maximum dollar amount per year of eligible charges payable by an Insured to Providers. Co-payment amounts and Prescription Drug costs do not apply to the Out-of-Pocket maximum amount and no individual family member may contribute more than one-half of the Family Out-of-Pocket maximum. Only eligible Deductible and co-insurance amounts (except co-insurance amounts paid towards Prescription Drugs or for any Benefits which are not eligible to be paid at 100%) that are paid by the Insured during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Deductible amounts must be satisfied for each individual family member (unless the Family Deductible has been satisfied) even if the Family Out-of-Pocket maximum amount has been satisfied. The Out-of-Pocket amounts are specified in the Schedule of Benefits section of this booklet.

“Owner” means an owner, partner or proprietor of the Policyholder. In order to be eligible for the optional 24-hour coverage endorsement, 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.

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

“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 or other facility confinement is Medically Necessary and that the proposed length of stay is appropriate. **Pre-certification does not guarantee payment or determine Benefit eligibility.** Pre-certification for an Emergency or for Urgent Care is **not** required. However, once the care is no longer an Emergency or Urgent Care, Pre-certification requirements will apply. In the event that Emergency or Urgent Care is pre-certified, the length of stay will not be retrospectively denied. Pre-certification is also **not** required a) when an Insured is involuntarily committed to a state hospital for the treatment of Mental Illness; b) for detoxification services; or c) for the treatment of craniomandibular and temporomandibular joint disorders if services are rendered due to an Accidental Injury and treatment begins within forty-eight (48) hours of the Accident.

“Preexisting Condition” is a physical or mental condition, regardless of the cause of the condition, for which medical advice, care or treatment was recommended or received within the three (3) months prior to the Enrollment Date. The term “Preexisting Condition” does not include pregnancy, does not include genetic information in the absence of a diagnosis of the condition related to such information, and does not include phenylketonuria (“PKU”).

“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 Facility, 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.

“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.

“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 or the state registered domestic partner of the Insured person.

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

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

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

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

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

“Waiting Period” means the time between the Employee’s date of hire and the date the Employee begins participation in the Plan.

III. ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE:

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

A. ELIGIBILITY DATE FOR EMPLOYEES OF NEWLY ENROLLED EMPLOYER GROUPS: Employees who worked an average of twenty (20) hours or more per week during the preceding month are eligible to participate in the Plan on the Effective Date of the Employer’s Plan, provided that they enroll in the Plan prior to the Employer’s Effective Date by submitting a properly completed enrollment card to the Company. Any eligible Employee who does not enroll prior to the Effective Date of the Employer’s Plan, is ineligible to enroll in the Plan until the next Open Enrollment period.

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

1. The satisfaction of the Employer’s eligibility requirements and Waiting Period; or
2. Their date of hire (if they maintained other health insurance coverage as of their date of hire); or
3. Thirty-one (31) days after their date of hire (if they did not maintain other health insurance coverage as of their date of hire); or

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

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

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

- C. **ELIGIBILITY DATE FOR DEPENDENTS:** Eligible Dependents may enroll in the Plan, by submitting a properly completed enrollment card to the Company, at the time of enrollment of the eligible Employee. Eligible Dependents who enroll at the same time as the Employee are eligible to participate in this Plan on the same day as the Employee. An eligible Dependent who does not enroll at the same time as the eligible Employee, other than a Special Enrollee, is ineligible to enroll in the Plan until the next Open Enrollment period.

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

1. Employees who declined participation in the Plan when they were first eligible because they maintained other health insurance and have since involuntarily lost the other coverage. If the other coverage is provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Employee may only enroll after the COBRA coverage has been involuntarily exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, enrollment must be requested within sixty (60) days after the termination.
2. Employees who marry or acquire a Child through birth, adoption, or placement for the purpose of adoption. The Employee must enroll within the first sixty (60) days of eligibility.
3. Eligible Dependents of Employees Insured under the Plan, when the eligible Dependent declined participation in the Plan when the Dependent was first eligible because other health insurance was maintained and the Dependent has since involuntarily lost the other coverage. If the other coverage is COBRA coverage, the Dependent may only enroll after the COBRA coverage has been involuntarily exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, enrollment must be requested within sixty (60) days after the termination.

4. Eligible Dependents of Insured Employees acquired due to marriage, state registered domestic partnership, 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, at the time of state registered domestic partnership, or when a Child is born, adopted or placed for the purpose of adoption. Enrollment must be within sixty (60) days of eligibility.
 - b. A newborn Child is automatically covered from the moment of birth for a period of sixty (60) days and an adopted Child is automatically covered from the date the Child is placed for the purpose of adoption for a period of sixty (60) 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 sixty (60) days from the date of birth or placement for adoption and must pay all applicable premium within the sixty (60) day period, in order for the coverage of a newborn or adopted Child to extend beyond the sixty (60) day period.
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 and they work an average of at least eighty (80) hours per month while receiving compensation for such service from the Employer. Eligibility may also be maintained if the Employee is on paid leave status of not more than six (6) months and if he worked an average of eighty (80) hours during the two (2) months immediately preceding the date he was placed on leave status.

F. MAINTENANCE OF GROUP ELIGIBILITY: The Company may terminate the Plan if the number of Employees Insured with Western Mutual Insurance Company is less than 50% of the number of Employees eligible for insurance. The Company requires that 100% of all of the Employees participate if there are less than three (3) Employees that are eligible for the insurance. The Company requires that 75% all of the Employees participate if there are less than ten (10) Employees that are eligible for the insurance. 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. In the event the required monthly premiums are not received timely by the Company, coverage will automatically be terminated as of the end of the last day for which a premium has been paid. Reinstatement of coverage for a terminated insurance group may be allowed provided that all requirements of the Company have been met. All premiums are due on the first day of each calendar month and shall be considered delinquent on or before the 10th day of the month that such premiums are due.
3. An Employee's insurance under this Plan may be immediately terminated if the Employee has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact under the terms of the coverage. 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 in 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 the Dependent has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact under the terms of the coverage. 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. If an Employee's covered Dependent(s) is incapable of self-support because of developmental disability or physical handicap on the date his coverage would otherwise terminate on account of age, and within thirty-one (31) days of that date the Employee submits to the Company satisfactory proof of his incapacity, his medical Benefits will be continued during the period of his incapacity. The

Company may subsequently require proof of his incapacity as specified in the Plan. This extension will continue until the earliest of:

- (a) The date he ceases to be incapacitated;
- (b) The thirty-first (31st) day after the Company requests additional proof of his incapacity if the Employee fails to furnish such proof; or
- (c) The last day in which premiums have been paid.

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

A. INPATIENT FACILITY SERVICES: The Medical Necessity and appropriateness of the length of stay of all Inpatient Facility services must be Pre-Certified, however, Pre-certification is **not** required for an Emergency or for Urgent Care. Once the care is no longer an Emergency or Urgent Care, the Pre-certification requirements will apply. In the event that Emergency or Urgent Care is pre-certified, the length of stay will not be retrospectively denied. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. Pre-certification is also **not** required a) when an Insured is involuntarily committed to a state hospital for the treatment of Mental Illness; b) for detoxification services; or c) for the treatment of craniomandibular and temporomandibular joint disorders if services are rendered due to an Accidental Injury and treatment begins within forty-eight (48) hours of the Accident. The company that must be contacted for Pre-certification before all non-Emergency admissions is shown on the insurance card. Emergency admissions must be reported within twenty-four (24) hours of the admission (or on the next business day if the admission occurs on a weekend or holiday). 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 Pre-certification company to request a review, which 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 per Disability. Room charges are covered as a separate expense.
3. Inpatient Hospital Intensive Care Unit. Eligible Expenses that are incurred in a Hospital Intensive Care Unit are covered up to a maximum of one hundred eighty (180) days per Disability.

4. **Inpatient Mental Illness Care.** Inpatient Mental Illness care is paid as set forth in the Schedule of Benefits. 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. Pre-certification is not required when an Insured is involuntarily committed to a state hospital for the treatment of Mental Illness.
 5. **Inpatient Chemical Dependency Treatment.** Treatment for Chemical Dependency is paid as set forth in the Schedule of Benefits. Treatment must be rendered in a Chemical Dependency Treatment Facility 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 amount of Covered Expenses for the daily room charge incurred at an Extended Care Facility/Rehabilitation Care Facility is limited to the most common daily charge for a Semi-private room by the Extended Care Facility/Rehabilitation Care Facility. All other Covered Expenses incurred will be paid in accordance with the policy guidelines. The Extended Care Facility/Rehabilitation Care Facility benefit is limited to a maximum of sixty (60) days in any one Calendar Year. Custodial Care is not considered Extended Care/Rehabilitation Care and is ineligible for Benefits.
- B. OUTPATIENT HOSPITAL SERVICES:** Outpatient services, supplies and treatment provided in an Ambulatory Service Facility are payable as set forth in the Schedule of Benefits.
- C. OUTPATIENT MENTAL ILLNESS CARE:** Outpatient Mental Illness services 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. OUTPATIENT CHEMICAL DEPENDENCY TREATMENT:** Outpatient expenses that are eligible are covered as set forth in the Schedule of Benefits. Care must be rendered by a Provider or Practitioner or in a Chemical Dependency Treatment Facility as those terms are defined in the Policy in order to be eligible for Benefits. Treatment 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.
- E. 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. The Plan also covers one surgical assistant per surgery if Medically Necessary, and payment is limited to 20% of the amount allowable under the primary surgeon's charges.

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 operative session through the same incision, the available Benefits shall be the value of the major procedure plus 50% of the value of the lesser procedure. When multiple procedures are performed through separate incisions or in separate sites, the available Benefit shall be the value of the major procedure plus 75% of the value of the lesser procedure. Incidental procedures such as an incidental appendectomy, incidental scar excision, puncture of ovarian cysts, and simple lysis of adhesions, are covered under the principal amount payable and no additional Benefit is available.
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.

F. 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 requested by the attending Physician are covered. One consultation is allowed per specialist per Disability.
 - (c) Limitations. There is a limit of one Physician or Provider Visit per day and Benefits expire after three hundred sixty-five (365) days of Hospital confinement per Disability (180 days is the maximum allowable under intensive care).
 - (d) Concurrent Physicians Services:
 - (i) A patient who has been hospitalized for a surgical procedure and who receives Hospital medical care from a Physician other than the surgeon for a condition not related to the surgical service received, 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 care only from the date of admission to the date of transfer to the surgical service. Thereafter, the patient is only entitled to the surgical 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 routine immunizations as set forth in the Schedule of Benefits.
5. The Plan covers back and spine manipulations and modalities as set forth in the Schedule of Benefits.
6. 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.
7. The Plan covers reconstructive breast surgery resulting from a mastectomy. The Plan covers all stages of one reconstructive breast surgery on the nondiseased breast to establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed

“Mastectomy” means the 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.

Benefits for reconstructive breast surgery include, but are not limited to, the costs of two prostheses, the cost of one mastectomy bra, and benefits for outpatient chemotherapy following surgical procedures.

- G. **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.

H. 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-authorized by the Company in writing. All transplants or implants may require a second opinion (and a third opinion), if deemed necessary by the Company. If the required opinion(s) are 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; and (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.

I. DIAGNOSTIC LABORATORY TESTS AND X-RAY EXAMINATIONS: If, as a result of Accidental Bodily Injury or Illness, the Insured requires any laboratory tests, x-ray examinations, pathological services, or machine diagnostic tests done solely for diagnostic purposes and authorized by the attending Physician and surgeon, expenses incurred for such procedures will be paid as set forth in the Schedule of Benefits.

J. ANESTHESIA SERVICES: The Plan covers anesthesia service to achieve general or regional (but not local) anesthesia at the request of the attending Physician and

performed by a Physician other than the operating Physician or the Assistant. Services of a nurse anesthetist who is not employed by the Hospital and who bills for services provided are also covered, but only if a Hospital employee or Physician-anesthesiologist is unavailable.

K. MATERNITY SERVICES:

1. Maternity Benefits are paid on a Dependent Spouse or female 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 unless more than two ultrasounds are deemed Medically Necessary by the Physician due to a condition of risk to the mother or child.
3. Benefits for prenatal diagnosis of congenital disorders of the fetus by means of Medically Necessary screening and diagnostic procedures will be provided in accord with standards set forth by the Board of Health.

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 of all types.
2. Oxygen and equipment for its administration. Equipment that meets the definition of Durable Medical Equipment will be paid in accordance with the Durable Medical Equipment benefit.
3. Blood transfusions, including the cost of blood and blood plasma.
4. X-ray, laboratory, and pathological services, and machine diagnostic tests.
5. Physical therapy rendered by a qualified licensed professional physical therapist and if prescribed by a Physician or a Physician's assistant as to type and duration. Physical therapy 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 as set forth in the Schedule of Benefits.
7. Orthopedic braces (except shoes or related supportive or corrective devices).
8. Purchase or rental (up to the purchase price) of Durable Medical Equipment as set forth in the Schedule of Benefits. 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 lost while the Insured was covered under this Policy as set forth in the Schedule of Benefits. Only the original prosthesis is eligible for Benefits.
10. Home nursing care by a registered nurse (RN) or licensed practical nurse (LPN) for a period not to exceed one hundred thirty (130) Visits in any one Calendar Year. 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 as set forth in the Schedule of Benefits.
12. Cardiac rehabilitation therapy, such as, but not limited to, the use of common exercise equipment while under a Physician's care in a formal rehabilitation program at an accredited facility, pursuant to a Physician's prescription. This Benefit is limited to a maximum of \$500 per occurrence. Cardiac rehabilitation therapy must be rendered within ninety (90) days following cardiac illness or surgery.
13. The first lens purchased in conjunction with cataract surgery is covered under Major Medical.
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 within one (1) year of Accidental Injury.
15. Circumcisions are covered as set forth in the Schedule of Benefits.

16. The Plan covers treatment for phenylketonuria (“PKU”) including medical services and dietary products. The dietary products must be prescribed by a Physician and must be the major source of nutrition for the Insured.
17. Reconstructive surgery and two 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. Expenses and Prescription Drugs purchased through the optional Prescription Drug Card rider do not apply to the Major Medical Deductible or the Out-of-Pocket yearly maximum. Prescription Drugs not purchased through the optional Prescription Drug Card rider will be paid as set forth in the Schedule of Benefits upon submission to the Company. Mail order drugs are only covered if purchased through the optional Prescription Drug Card rider. Generic Prescription Drugs must be used whenever a generic equivalent is available. 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 of care. If a brand name drug is purchased instead of a generic equivalent, the Insured is responsible for the price difference. Prescription drugs that exceed the manufacturer’s recommended dosage or the dosage established by the Food and Drug Administration (“FDA”) are not covered. There are no Benefits for Prescription Drugs if the optional Prescription Drug card rider has not been selected.

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 as set forth in the Schedule of Benefits. Treatment to diagnose and to correct snoring is not covered.
20. Pulmonary rehabilitation therapy while under a Physician's care in a formal rehabilitation program at an accredited facility pursuant to a Physician's prescription. This benefit is limited to a maximum of \$500 per occurrence and must be within ninety (90) days following the diagnosis of pulmonary illness or surgery.
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;

- (m) Medically Necessary podiatric appliances for the prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and
 - (n) glucagon emergency kits.
23. Diabetes self-management training and education, including medical nutrition therapy, when deemed medically necessary and prescribed by an attending physician, and when provided by a health care Practitioner with an expertise in diabetes.
 24. Expenses for Prescription Drugs or devices for contraception, including treatment or services rendered in connection with placement or removal of such drugs or devices. Expenses for Prescription Drugs for contraception are eligible for Benefits only if the optional Prescription Drug card rider has been elected and premiums have been paid.
 25. Emergency care, as defined in the Policy, that is rendered by a non-Preferred Provider, and where the Insured could not reasonably reach a Preferred Provider, will be reimbursed as though the Insured had been treated by a Preferred Provider.
 26. Expenses for general anesthesia and related facility charges in conjunction with any dental procedure performed in a Hospital or Ambulatory Service Facility are covered if such expenses are Medically Necessary because the Insured individual: 1) is under the age of seven (7), or is physically or developmentally disabled, and has a dental condition that cannot be safely and effectively treated in a dental office; or 2) has a medical condition that, as determined by a Physician, would place the individual at undue risk if the dental procedure were performed in a dental office.
 27. Expenses for neurodevelopmental therapies for Insureds age six (6) and under are covered if Medically Necessary and if rendered by, or referred by, a Physician, subject to a written treatment plan. Benefits shall be provided to restore and improve function, and shall include such services as Occupational Therapy, speech therapy and physical therapy. Benefits shall be subject to the Deductible and applicable co-insurance amounts, and shall be limited to **\$1,500** per Calendar Year.
 28. Expenses for acupuncture and acupressure are covered when performed by a Practitioner or Provider as defined in the Policy.
 29. Expenses for massage therapy are covered when performed by a Practitioner or Provider as defined in the Policy.
 30. 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.

Benefits are only available if the optional Prescription Drug Card rider has been elected and premiums have been paid.

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 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 automobile No-Fault insurance coverage, when such coverage is in force. Credit will be applied towards the Deductible and Out-of-Pocket amounts under this Policy after such expenses have been paid by the automobile or vehicle medical payment coverage, and upon receipt by the Company of proof of such payment.
5. Expenses for any loss to which the contributing cause was the Insured's or Dependent's commission of, or attempt to, commit a felony; or to which a contributing cause was the Insured's being engaged in an illegal occupation.
6. Care or treatment of an Accident, Illness or Injury caused by, or arising out of the following: the Insured's commission of an act of 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 committed by a person entitled to Benefits.
7. Examinations, reports, or appearances that are in connection with legal proceedings. This exclusion also applies to services, supplies, or accommodations provided pursuant to a court order, whether or not Illness or Injury is involved.
8. Experimental or Investigational Treatments or Procedures. This exclusion also applies to services, supplies, or accommodations provided in connection with the same.
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 provided that the expenses are incurred within one (1) year of the date of Injury, for reconstructive surgery following a mastectomy, or for repair of a congenital anomaly. The Preexisting Condition limitation applies to the exception to this general exclusion.

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 1) a gastric or intestinal bypass; 2) balloon implant; 3) gastric stapling; or 4) other similar surgical procedure.
13. Expenses for treatment or services rendered in connection with invitro fertilization or artificial insemination.
14. Expenses in connection with genetic studies, genetic testing, or genetic counseling.
15. Expenses for the care or the treatment of mental conditions unless and until there exists a confirmed diagnosis of a Mental Illness as defined in the policy. The diagnosis of a Mental Illness must be made pursuant to a personal examination of the patient by a Provider that is licensed to make such a diagnosis.
16. Expenses made which are in excess of Usual and Customary charges accepted as payment for the same service within a geographic area.
17. 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.
18. Expenses for milieu therapy; modification of behavior; biofeedback; or sensitivity training.
19. Care or treatment of psychosexual identity disorder; transsexualism; sexual transformation; or psychosexual dysfunction.
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 reesterilization.
23. Expenses for rest cures.

24. Expenses in connection with institutional care, which (as determined by the Company) is for the primary purpose of controlling or changing the environment of the Insured.
25. Expenses in connection with Inpatient charges for a Residential Care Facility/Institution are not covered. Expenses that would otherwise be eligible for Benefits if not provided in this type of facility will be considered for Benefits on an outpatient basis, subject to all other Policy provisions, if billed separately from the facility charges.
27. Expenses for facility charges at an Ambulatory Service Facility or a Hospital when the facility is not approved by the Joint Commission on Accreditation of Hospitals (“JCAH”).
28. 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.
29. 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).
30. Expenses for which the Insured, the Insured person, or his guardian is not legally obligated to pay.
31. Expenses for any services associated with pregnancy for a Dependent Child. **Note:** This exclusion does not apply to services associated with Complications of Pregnancy as defined in the Policy.
32. Expenses for any services or products unless the services or products were:
 - (a) Medically Necessary; and
 - (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, or when Medically Necessary and specifically prescribed by a Physician with a Prescription Order.
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 provided that the expenses are incurred within one (1) year of the onset of the Illness or the date of Injury. This exclusion also does not apply for neurodevelopmental therapies as described elsewhere in this Policy. The Preexisting Condition limitation applies to the exception to this general exclusion.

36. Expenses for transportation (except Medically Necessary ambulance services as set forth in the Schedule of Benefits). This exclusion includes, but is not limited to, the following:
 - (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; and
 - (c) Ambulance services beyond transportation to the nearest facility 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 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 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; 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 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.
43. Expenses for services incurred for the drainage of an intraoral alveolar abscess.
44. 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 this coverage has been selected and premiums have been paid.
45. 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.

46. 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.
47. 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 (this exclusion does not apply to eligible expenses that are provided for the treatment of diabetes); or
 - (c) Treatment (including cutting or removal by any method) of toenails (other than the removal of the nail matrix or root), corns, or calluses.
48. Expenses for corrective shoes (unless they are an integral part of a lower body brace) or for special shoe accessories.
49. Expenses for services provided by an immediate relative of the Insured or by an individual who customarily lives in the same household with the Insured.
50. Expenses for radioallergosorbent (“RAST”) testing.
51. Expenses for preventative medication; non-prescription vitamins; mineral and nutrient supplements; fluoride supplements; food supplements; sports therapy equipment; services and applications of such.
52. Expenses for anabolic steroids; weight-reduction drugs; growth hormones; and non-prescription hematinics.
53. Expenses for services, supplies, and treatment for hair loss, including, but not limited to, the use of minoxidil and Rogaine.
54. Expenses for experimental drugs; non-legend drugs; smoking deterrents; anti-wrinkle agents; and Tretinoin, all dosage forms (for example, Retin A) for Insureds over twenty-five (25) years of age.
55. Expenses for autopsy procedures.
56. Medicines that, by a law of the United States, require a Physician’s Prescription (except for insulin, testing supplies, and syringes for diabetes.) This exclusion does not apply if the optional Prescription Drug card rider has been elected and premiums have been paid.
57. Expenses for treatment or services rendered in connection with artificial insemination; invitro fertilization; all procedures to preserve sperm and ova;

- Prescription Drugs to induce fertility; gamete intrafallopian transfer (“GIFT”); and any other procedures designed to help or treat infertility.
58. Expenses for the care or treatment of elective surgery; complications of elective surgery; or complications of an ineligible procedure.
 59. Expenses for circumcisions not performed within thirty (30) days of birth or adoption.
 60. Expenses related to treatment for infertility including Prescription Drugs and medications.
 61. All shipping, handling, delivery, sales tax, or postage charges, except as incidentally provided in connection with Covered Services or supplies.
 62. Expenses for Occupational Therapy. This exclusion does not apply to neurodevelopmental therapies or Home Health Care as described elsewhere in this Policy.
 63. Expenses for an elective abortion, including any medications/Prescription Drugs that are for the purpose of inducing abortion. An “elective abortion” means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
 64. Expenses that are incurred as the result of the Insured or any insured person committing a fraudulent insurance act.
 65. Care rendered outside of the United States, except Urgent Care or emergency care.
 66. Drugs and medicines that are available over the counter, or that do not require a Prescription Drug Order.
 67. 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.

VII. PREEXISTING CONDITIONS:

- A. **PREEXISTING CONDITION LIMITATION:** During the three (3) months following the Enrollment Date, no Benefits will be provided under this agreement for any of the following; however, this time period will be reduced by the number of days of Creditable Coverage calculated as of the Enrollment Date of the Insured:
 1. A Preexisting Condition as defined in this Policy.

The Company will not deny, exclude, or limit Benefits for a covered individual for losses incurred more than three (3) months following the Enrollment Date of the individual's coverage due to a Preexisting Condition.

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

VIII. COBRA, USERRA, EXTENSION OF BENEFITS, AND CONVERSION:

- A. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"):** If the Insured's Employer employs more than 20 Employees on an average business day during the previous Calendar Year, federal law provides that the Employee and/or his Dependents may be entitled to continue insurance Benefits after termination of group health benefits upon a qualifying event for 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. Western 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 with no preexisting condition limitation.
5. The maximum continuation coverage period expires.

- B. The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"):** If an Insured Employee is absent from employment due to service in the uniformed services, federal law provides that the Employee and his dependents are entitled to continue health insurance coverage for a period of up to twenty-four (24) months. Election of the continuation coverage must be made in writing within sixty (60) days of the date of commencement of any leave for military service.

Continuation coverage will automatically terminate if the Employee fails to pay the required premium, or if the Employee loses his rights under USERRA as a result of undesirable conduct, including court-martial and dishonorable discharge.

When an Insured Employee loses coverage under the group health Plan because the Employee leaves work to perform military service, and the group health Plan is subject to COBRA, the Employee and the Employee's Dependents will be entitled to protections of both COBRA and USERRA. When the requirements of COBRA and USERRA differ, the Employee and the Employee's Dependents are entitled to protection under the law that gives the greater benefit.

The term "uniformed services" means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

C. Extension of Benefits - General:

1. An individual whose insurance under the group Policy has been terminated has the right to continue coverage under the group Policy for a period of ninety (90) days (**Note: your Employer may have negotiated a different time period than this one, or may have chosen to eliminate this benefit. Please verify your company's specific requirements with your Employer.**) This right to continue coverage does not apply if 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 immediately provide the Insured written notification of the right to continue group coverage when the Employee's coverage is so suspended or terminated. The notice shall state the payment amounts required for continued coverage, to be paid directly by the Employee to the Employer, including the manner, place, and time in which the payment shall be made. The notice may be sent to the 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 members, 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 premium amount required within the time specified, 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.

D. Extension of Benefits due to Labor Dispute:

1. An Employee whose coverage is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute, has the right to continue coverage under the group Policy for a period of six (6) months. This right to continue coverage includes any Dependent coverage. When applicable, any extension of coverage required by federal law may run concurrently with the requirements of this section.

The Employer shall immediately provide the Insured written notification of the right to continue group coverage when the Employee's coverage is so suspended or terminated. The notice shall state the payment amounts required for continued coverage, to be paid directly by the Employee to the Employer, including the manner, place, and time in which the payment shall be made. The notice may be sent to the Insured's home address as shown on the records of the Employer.

After the six (6) month extension period, if such insurance coverage is no longer available, the Employee has the right to be covered under one of the Company's conversion plans.

E. Conversion Plans: An Individual whose insurance under the group Policy has been terminated has the right to be covered under one of the Company's Conversion Plans when group coverage terminates. An individual does not have conversion rights if:

2. Termination of the group coverage occurred because of failure of the Employee to pay any required individual premiums;
3. Termination of the group coverage occurred because the Employee's employment was terminated due to gross misconduct; provided, that a conversion policy shall be offered to the Spouse and/or dependents of the terminated Employee;
4. The Insured is eligible for federal Medicare coverage;
5. The Insured acquires other group health coverage that is comparable to the coverage under the conversion plan;

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

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

Written application for the conversion policy shall be made and the first premium shall be paid to the Company no later than thirty-one (31) days after termination of the group coverage. The premium must bring the insurance premium current with no lapse of coverage.

IX. COORDINATION OF BENEFITS, WORKERS' COMPENSATION EXCLUSION, THIRD PARTY LIABILITY AND PERSONS COVERED BY MEDICARE:

A. COORDINATION OF BENEFITS:

All of the Benefits provided under this Policy are subject to this Coordination of Benefits (COB) provision. This provision applies when an Insured has health care coverage under more than one plan. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

A plan is any of the following that provides benefits or services for medical care or treatment: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage other under federal governmental plans, unless permitted by law.

For purposes of this Coordination of Benefits provision, the following definitions apply: 1) "**allowable expense**" means any health care expense, including deductibles, coinsurance and copayments, that is covered in full or in part by any of the plans covering the Insured. An expense that is not covered by any plan covering the Insured is not an allowable expense. When a plan provides benefits in the form of

services or supplies, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense; and 2) “**claim determination period**” means Calendar Year.

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.

If the other health care plan contains a Coordination of Benefits provision, each plan determines its order of benefits using the first of the following rules that applies:

1. **Non-Dependent or Dependent.** The benefits of the health care plan which covers the person (to whom the claims relate) as other than a Dependents(s), for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and a plan that covers the person as a Dependent(s) is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent, and primary to the plan covering the person as other than as a Dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber, policyholder, or retiree is the secondary plan and the other plan is the primary plan.
2. **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one plan the order of benefits is determined as follows:
 - a) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
 - b) For a Dependent Child whose parents are divorced or separated or are not living together, whether or not they have ever been married, the following rules apply:
 - i) If a court decree states that one of the parents is responsible for the Dependent Child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is the primary plan. If the parent with responsibility has no health care coverage for the Dependent Child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision.
 - ii) If a court decree states that one of the parents is to assume financial responsibility for the Dependent Child but does not mention

responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary.

- iii) If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of subsection (b)(i) above determine the order of benefits.
 - iv) If a court decree states that the parents have joint custody without specifying that one parent has financial responsibility or responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of subsection (b)(i) above determine the order of benefits.
 - v) If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the Dependent Child are as follows:
 - A) The plan covering the custodial parent, first;
 - B) The plan covering the spouse (if any) of the custodial parent, second;
 - C) The plan covering the non-custodial parent, third; and then
 - D) The plan covering the spouse (if any) of the non-custodial parent, last.
 - c) For a Dependent Child covered under more than one plan of individuals who are not the parents of the Dependent Child, the provisions of subsections (a) or (b) above determine the order of benefits as if those individuals were the parents of the Dependent Child.
3. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active Employee, that is, an employee who is neither laid-off nor retired, or as a Dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid-off employee, or as a Dependent of a retired or laid-off employee, is the secondary plan. If the other health care plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This provision does not apply if the provision under section A(1) can determine the order of benefits.
4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation according to state or other federal law is covered under another plan, 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 under COBRA or under a right of continuation according to state or other federal law is the secondary plan.

If the other health care plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This provision does not apply if the provision under section A(1) can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan.
6. If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans.

Effect on Benefits: When this Plan is secondary, it may reduce its Benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. In determining the amount to be paid for a claim, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid by all plans equal one hundred percent (100%) of the total allowable expense for that claim. The total allowable expense is the highest allowable expense of the primary plan or the secondary plan. The secondary plan must also credit to its plan deductible any amounts it would have credited to its deductible in the absence of the other health care coverage.

In addition, the secondary plan must calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid as a primary plan. These savings are recorded as a benefit reserve for the covered individual and must be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered individual during the claim determination period.

Facility of Payment: If payments that should have been made under this Plan are made by another plan, the Company has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. To the extent of such payments, the Company is fully discharged from liability under this Plan.

Right of Recovery: The Company has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person, other insurance company or other organization that has received payment.

Notice to Covered Persons: If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan

you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty (30) calendar days.

CAUTION: All health plans have timely filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

B. WORKER'S COMPENSATION EXCLUSION: Expenses for which payment is required under applicable workers' compensation statutes are not eligible for payment under this medical Plan. This Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance.

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

1. **Recovery Rights:** Up to the amount of Benefits paid in connection with the Illness or Injury, the Company shall be entitled to the proceeds of any settlement or judgment which results in a recovery from the third party. The Company's right to subrogation shall not be enforced until the Insured has been fully compensated for his Illness or Injury.
2. If the Insured does not seek recovery from the responsible third party, the Insured shall hold the rights of recovery against the third party in trust for the Company up to the amount of Benefits paid in connection with the Illness or Injury.
3. The Company shall pay out of such proceeds actually recovered a proportionate share of any reasonable expense incurred in effecting collection from the third party or his insurer.
4. Receipt by the Insured or on behalf of the Insured of any Benefits in connection with the Illness or Injury shall constitute the Insured's unconditional agreement to each and all of the provisions set forth in this Plan.

D. PERSONS COVERED BY MEDICARE:

1. This Plan will pay its Benefits before Medicare for:
 - (a) An active Employee who is age sixty-five (65) or older and is with a group of twenty (20) or more Employees, as that term is defined in the Medicare secondary payer rules.
 - (b) A Dependent spouse who is age sixty-five (65) or older, of an active Employee who is employed with a group of twenty (20) or more Employees, as that term is defined in the Medicare secondary payer rules.

- (c) The time period required by federal law during which Medicare is the secondary payer to a group health plan and the Insured individual is receiving treatment for end-stage renal disease (ESRD).
- 2. If the Dependent spouse is also actively employed and enrolled under a group health plan provided by the spouse's Employer, this Plan shall then be secondary to that coverage and Medicare becomes the third payer.
- 3. This Plan will pay Benefits only after Medicare has paid its Benefits:
 - (a) For all other Insured persons; and
 - (b) After the time period required by federal law, during which Medicare was the secondary payer to a group health plan and the Insured individual received treatment for end-stage renal disease (ESRD).

X. GENERAL POLICY INFORMATION:

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

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

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

- 1. On any premium due date provided the rate for such insurance has been in effect for at least three (3) months by giving written notice to the group Policyholder at least sixty (60) days prior to such premium due date; or
- 2. On any date the provisions of this Plan are changed as to the Benefits provided or classes of persons Insured.

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

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

- C. **GRACE PERIOD:** A grace period of thirty-one (31) days will be allowed for payment of any premium due, unless the Policyholder gives written notice of discontinuance prior to the premium due date.
- D. **TERMINATION OF POLICY:** If the Policyholder fails to pay any premium within the grace period, this Plan shall automatically terminate on the last day of such grace period, but the Policyholder shall, nevertheless, be liable to the Company for the payment of all premiums then due and unpaid, including a pro rata premium for the grace period. If, however, written notice is given by the Policyholder to the Company, during the grace period, that this Plan is to be terminated before the expiration of the grace period, this Plan shall be terminated as of the date of receipt of such written notice by the Company or the date specified by the Policyholder for such termination, whichever date is later, and the Policyholder shall be liable to the Company for the payment of all premiums then due and unpaid, including a pro rata premium for the period commencing with the last premium due date and ending with such date of termination.
- E. **RECORD OF EMPLOYEES INSURED:** The Company shall maintain a record which shall show at all times the names of all Employees insured hereunder, the beneficiary, if any, designated by each such Employee, the date when each Employee became insured and the Effective Date of any change in coverage and such other information as may be required to administer the insurance hereunder. The Company shall furnish the Policyholder, upon its reasonable request, a copy of such record. The Policyholder shall furnish periodically to the Company such information relative to Employees becoming insured, changes in coverage, and termination of insurance as the Company may require for the administration of the insurance hereunder. Any records of the Employer and/or Policyholder that may, in the opinion of the Company have a bearing on the insurance hereunder, shall be open for inspection by the Company at a reasonable time.
- F. **EMPLOYEE'S CERTIFICATE:** The Company will issue, as appropriate, directly to the Insured Employee, or to the Policyholder, for delivery to each Insured Employee, an individual certificate setting forth a statement as to the insurance protection to which he/she is entitled, to whom the Benefits are payable, and such limitations or requirements in this Plan as may pertain to the Insured Employee. The word "certificate" as used in this Plan shall include certificate riders and certificate supplements, if any.
- G. **CLAIM PROCEDURES:** Following is a description of how the Plan processes claims. 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, unless otherwise specified.

Pre-Service Claim

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

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

Post-Service Claim

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

In the event of a post-service claim, the Insured will receive a notification of the benefit determination within twenty (20) **working** 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.

H. GRIEVANCE PROCEDURES:

Complaint

A complaint is an oral or written request for review submitted by, or on behalf of, an Insured regarding a denial of health care services or payment for health care services, dissatisfaction with health care services, delays in obtaining health care services, conflicts with Company staff or providers, or dissatisfaction with Company practices

or actions unrelated to health care services. The complaint process is an informal process for the Company to correct errors, clarify Benefits, and take steps to improve customer service. The complaint must be submitted to the Company within thirty (30) days of the occurrence of the dissatisfaction. The Company will review all applicable information and will provide a written determination that sets forth the decision within thirty (30) days after receipt of the complaint. If an Insured receives an adverse decision, he may submit a formal appeal as described in the following section.

Formal Appeals

An appeal is an oral or written request for review of a) an adverse complaint decision; or b) an adverse benefit determination. Although oral appeals will be accepted, it is recommended that appeals be submitted in writing in order to better document the process. Within five (5) business days of receiving an appeal request, the Plan will send a written acknowledgement of receipt. Time periods begin at the time that an appeal is received, and “days” refers to calendar days, unless otherwise specified.

Appeals for Adverse Complaint Decisions

The Plan provides two levels of appeal review for appeals of an adverse complaint decision, which will be performed internally. Both of these levels are required levels that must be exhausted before an Insured can file suit in court. An Insured has one-hundred eighty (180) days from the receipt of the adverse complaint decision in which to file a first level appeal. An insured may submit any additional information that will be helpful in the review. 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. The first level of appeal will be responded to within fourteen (14) days of receipt of the appeal, unless the Company notifies the Insured that an extension is necessary to complete the appeal. In no event will the extension delay the decision beyond thirty (30) days of the receipt of the appeal, without the informed, written consent of the Insured. The second level of appeal will be responded to within thirty (30) days after the receipt of the appeal.

Appeals for Adverse Benefit Determinations

The Plan provides three levels of appeal review for appeals of an adverse benefit determination, 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. An Insured has one-hundred eighty (180) days from the receipt of the adverse benefit determination in which to file a first level 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.

Time Period for Appeal Review - In the case of a pre-service claim, the first level of appeal will be responded to with fourteen (14) days after the receipt of the appeal. The second 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, the first level of appeal will be responded to within fourteen (14) days of receipt of the appeal, unless the Company notifies the Insured that an extension is necessary to complete the appeal. In no event will the extension delay the decision beyond thirty (30) days of the receipt of the appeal, without the informed, written consent of the Insured. The second level of appeal will be responded to within thirty (30) days after the receipt of the appeal (**exception: if the appeal is for a denial due to an experimental or investigational service, the appeal will be responded to within twenty (20) working days after the receipt of the fully documented appeal.**)

Expedited Appeal – If the patient’s provider reasonably determines that following the appeal process response timelines could seriously jeopardize the patient’s life, health, or ability to regain maximum function, the decision regarding the expedited appeal will be made within seventy-two (72) hours from the date that the appeal is received.

For pre-service claims, both levels of appeal must be submitted 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 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 first or second level of 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 appeal, he has the right to file suit in court pursuant to §502 of the Employee Retirement and Income Security Act (“ERISA”).

Third Level Appeal – Independent Review - If an Insured receives an adverse benefit determination on the second level of appeal, or if the Plan has exceeded the

timelines for response without good cause and without reaching a decision, he may appeal to the third **voluntary** level by submitting a written request within thirty (30) days from the receipt of the determination notification, along with any additional applicable information. Within three (3) business days of receiving the request, the appeal will be sent to an Independent Review Organization (“IRO”) that is certified by the state Department of Health. The Insured and the treating provider will be notified in writing of the IRO’s decision. There will be no fee charged to the Insured for an independent review.

Ongoing Care - If an Insured appeals an adverse benefit determination for an otherwise covered service that has been determined to no longer be Medically Necessary or appropriate, the Plan will continue to provide Benefits for the service until the appeal is resolved. If the resolution of the appeal affirms the original decision, the Insured will be responsible for the cost of the continued service and will be required to repay any amounts paid during the appeal review period.

- I. **CONFORMITY WITH LAW:** If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.
- J. **EXPERIENCE RATING REFUNDS:** This Plan shares in the surplus earnings of the Company. Surplus earnings are defined as the amount of earnings in excess of earnings required to maintain minimum compulsory surplus required by law and the amount required to maintain an appropriate level of financial reserve as determined by the Board of Directors in its sole discretion.

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

- K. **NON-ASSESSABLE PLAN:** This Plan is not an assessable plan.
- L. **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.
- M. **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.
- N. **AMENDMENT AND ALTERATION OF CONTRACT:** This Plan may be amended at any time, subject to the laws of the jurisdiction in which it is delivered,

without the consent of the Employees insured hereunder or of their beneficiaries, by written agreement between the Policyholder and the Company. This Plan may also be amended on the Plan's renewal date upon ninety (90) days written notice from the Company to the Policyholder. No modification or amendment of this Plan shall affect the right or the extent of Benefits of any Insured Employee or Insured Dependent who is, on the Effective Date of such modification or amendment, Hospital confined or confined in an Extended Care Facility until the first discharge therefrom occurring after such Effective Date. No change in the Plan shall be valid until approved by a duly authorized officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change any Plan or waive any provision thereof.

- O. **NOTICE AND PROOF OF CLAIM:** Written or electronic claim must be submitted to the Company within three-hundred sixty-five (365) days of the Date Incurred for which Benefits arising out of each Injury or Illness may be claimed. Unless otherwise excused as provided below, failure to timely file such claim shall release the Company from any liability to pay such claim. Notice given by, or on behalf of, the claimant to the Company at its Home Office or to any authorized agent of the Company, with particulars sufficient to identify the Insured Employee or Insured Dependent, shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in the Plan shall not invalidate any claim if it is shown that it was not reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

The Company, upon receipt of the notice required by the Plan, will furnish to the claimant such forms as are usually furnished by the Company for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the Company receives such notice, the claimant shall be deemed to have complied with the requirements of the Plan of filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claims are made.

- P. **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 pendency 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.

- Q. **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.

- R. **MEDICAL RECORDS:** The Company shall have the right to request and receive, without cost or expense, and as a condition precedent to liability for any Benefits to be provided under this Plan, medical records relating to care and treatment of any Insured who claims Benefits under this Plan. The Insured, by requesting any Benefits hereunder, does fully authorize, empower, and direct his/her Provider to furnish the Company with such complete reports and medical records.
- S. **OVERPAYMENTS:** If for any reason the Company pays any amount to, or on behalf of, the Insured:
1. For services not covered under this Plan, or
 2. Which exceed amounts to be paid as Benefits under this Plan, or
 3. On behalf of a person believed to be a Dependent who is not covered under this Plan,
- the 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 claims payments to the same provider for services rendered to the same Insured.
- T. **LEGAL PROCEEDINGS:** No action of law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, 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.
- U. **TIME LIMITATION:** If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Policy is delivered, such limitation shall be extended to agree with the minimum period permitted by such law.
- V. **INTERPRETATION:** Whenever the context of this Plan requires, the singular shall include the plural, the plural shall include the singular, the whole shall include any part thereof, and any gender shall include both genders. The captions which precede parts of this Plan are for reference only and shall not affect the manner in which any provision hereof is construed. Words that are capitalized throughout this document shall have the meaning prescribed to them in the Definitions section of this document.
- W. **SUPERSEDED PLAN:** In the event this Plan is issued to supersede a health care Plan previously issued by the Company, Benefits furnished under the previous health Plan shall apply against the Benefit maximums of this Plan as though such Benefits had been furnished under this Plan.
- X. **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 and Customary rate and will be reimbursed at a lower percentage level.

- Y. **RIGHTS UNDER ERISA:** If the Insured has any questions about the Plan, he or she should contact the Company. If the Insured has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), he or she should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor 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.
- Z. **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 QMCSO procedures may be obtained free of charge, upon request.

XI. PRIVACY POLICY

We at Western 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.

Western Mutual Insurance[®] Company

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