WMI Mutual Insurance™ Company

Medicare Supplement Policy Plan F

This Policy is issued by the Company at its home office. The home office address is 4393 South Riverboat Road, Suite 380, Taylorsville, UT 84123. This Policy is a legal contract between the Insured and the Company.

Notice to Buyer: This policy may not cover all of your medical expenses.

READ YOUR POLICY CAREFULLY

THIRTY DAY RIGHT TO EXAMINE THE POLICY

This policy can be returned to the Company at any time within thirty (30) days after you receive it. Upon its return, the Policy will be considered void from its inception. Any premium paid will be refunded to you. To return the Policy, mail or deliver it to our Home Office, or to the agent who sold it to you.

POLICY RENEWAL

This policy is guaranteed renewable from month to month. The Company reserves the right to change the applicable premium on thirty (30) days written notice to the Insured. The policy will automatically be terminated if the premium is not paid within the allowed grace period.

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I. DEFINITIONS

This Medicare Supplement benefit plan incorporates by reference all definitions of Medicare. The definitions listed below are for the convenience of the Insured and are not meant to change the definitions found in Medicare. If there is any variation between the definitions and terms of this Agreement and the definitions and terms in Medicare, the definitions and terms in Medicare shall govern.

"Assignment" is an agreement between a Physician (or other Provider) and the Insured whereby the Insured transfers his/her right to benefits based on covered services specified on the assigned claim, and in return, the Physician or the Provider agrees to accept the approved amount determined by Medicare as the full charge for the items or services.

"Benefit Period" means the way that Medicare measures your use of Hospital and Skilled Nursing Facility services. A Benefit Period begins on the first day you receive service as an inpatient in a Hospital or Skilled Nursing Facility and ends after you have been out of the hospital and have not received Hospital or skilled nursing care in any other facility for 60 consecutive days. If you go into the Hospital after one Benefit Period has ended, a new Benefit Period begins.

"Coinsurance" means the amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

"Company" means WMI Mutual Insurance Company (WMI).

"Deductible" means the amount you must pay for health care before original Medicare begins to pay.

"Effective Date" is the date on which the policy becomes effective.

"Hospital" means a facility which is licensed and 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.

"Illness" means a sickness or disease of body or mind of an Insured person.

"Injury" means accidental bodily damage which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.

"Insured" means any person to whom WMI issues a policy.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

"Physician" means an individual who is licensed under state law to practice medicine or osteopathy.

"Preexisting Condition" means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months before the Effective Date.

"Premium" as used herein, means the amount charged as consideration for this policy.

"Skilled Nursing Facility" means a nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

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

II. INTRODUCTION

THIS AGREEMENT SUPPLIES MEDICARE BENEFITS

1. **Medicare Benefits Must Be Determined First**
   Benefits will not be provided under this policy unless they are for services and supplies that are payable under Medicare, such as those that are specifically listed in Part III. Benefits which cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare Deductible amount and Coinsurance percentage factors. Premiums may be modified to correspond with such changes.

2. **To Whom Benefit Payments Are Made**
   Benefit payments shall be made directly to the Physician or provider if they have accepted Assignment. Such payment will not exceed the amount allowed by Medicare. The payment shall be made directly to the Insured if an Assignment has not been accepted.

III. PLAN F

A. BASIC ("CORE") BENEFITS

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period.

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate standard of payment, to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the Company's payment as payment in full and may not bill the Insured for any balance.

4. Coverage under Medicare Parts A and B for the reasonable costs of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B Deductible.

6. Coverage for the copayment/coinsurance amount for all Part A Medicare eligible hospice care and respite care expenses.

B. MEDICARE PART A DEDUCTIBLE

Coverage for 100% of the Medicare Part A inpatient hospital Deductible amount per Benefit Period.

C. MEDICARE PART B DEDUCTIBLE

Coverage for 100% of the Medicare Part B Deductible amount per calendar year regardless of hospital confinement.

D. SKILLED NURSING FACILITY CARE

Coverage for the actual billed charges up to the coinsurance amount from the twenty-first (21st) day through the one hundredth (100^{th}) day in a Medicare Benefit Period for post-hospital skilled nursing facility care eligible under Medicare Part A.

E. MEDICARE PART B EXCESS CHARGES

Coverage for one hundred percent (100%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

F. FOREIGN TRAVEL EMERGENCY CARE

Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year Deductible of two hundred fifty ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

IV. BENEFITS NOT PROVIDED

LIMITATIONS AND EXCLUSIONS

A. PREEXISTING CONDITIONS

No benefits shall be provided during a period of six (6) months following the Effective Date for a condition where medical advice or treatment was recommended or received during the six (6) months prior to the Effective Date.

If this policy replaces a group or individual health insurance policy or another Medicare supplement policy, the Company shall waive any time periods applicable to Preexisting Conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original policy, provided that there is no more than a sixty-three (63) day break in coverage.

B. EXCLUSIONS. Benefits are not available under any part of this contract for any of the following:

1. Any service, supply, or accommodation that is excluded under Medicare, except as specifically provided in Plan A.

2. Services and supplies for any Illness or Injury for which any benefit is payable to the Insured under any worker's compensation law or any other similar legislation. This exclusion applies whether or not application for or payment for such benefit has been made. Services and supplies which are furnished without any cost to the Insured under the laws of the United States, any foreign country, or any state or political subdivision thereof are also excluded. In no event will benefits be paid for services or supplies that are provided by the Veterans Administration.

3. Services and supplies for which no charge is made, or for which the Insured has no legal obligation to pay or cause to be paid.

4. Treatment of any condition, disease, ailment, Injury, or diagnostic service to the extent that benefits are provided or would have been provided had the Insured enrolled, applied, or maintained eligibility for such benefits under Medicare including amendments thereto.

5. Any services that are rendered or expenses that are incurred prior to the Effective Date or after the termination date of this Policy.

6. Care or treatment of an Illness or an Injury caused by or arising out of war, declared or undeclared, or any act of war.

V. PREMIUMS

A. Premium Due Date: The premiums that are required shall be billed and payable on a monthly basis. A grace period of thirty-one (31) days will be allowed for payment of any premium due, during which time the Policy shall continue in force. The Company reserves the right to change the applicable premium on thirty (30) days written notice to the Insured. Continued payment of such premiums by the Insured shall be conclusive proof that the Insured agrees to such changes.

B. Termination of Policy by the Company: The term of this policy shall be for one month from its Effective Date. This Policy shall be guaranteed renewable from month to month subject to the right of the Company to terminate or modify it on thirty (30) days written notice to the Insured. The Policy may only be terminated or nonrenewed by the Company due to nonpayment of premium or material misrepresentation. The Policy shall not be terminated by reason of any Insured's age or health. Such termination or modification shall be effective on the date stated in the notice. Such termination or modification

shall not affect the right to benefits for inpatient services that are rendered by a Hospital if the Insured's admission occurred prior to the effective date of such notice.

C. Termination of Policy by the Insured: The policy may be canceled by the Insured upon written notice to the Company. Such cancellation shall take effect on the first day of the month following the receipt of such notice by the Company. The Company shall refund any unearned premium that was paid beyond the date of cancellation.

D. Non-Payment of Premium: This contract shall terminate automatically without the requirement of notice to the Insured and shall be of no further force or effect if Premiums are not paid within the grace period. No right of conversion to an individual contract is allowed upon such cancellation.

E. Reinstatement: If any renewal premium is not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept the premium, without also requiring an application for reinstatement, shall reinstate the Policy. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the forty-fifth (45^{th}) day following the date of the conditional receipt, unless the Company has previously notified the Insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such Accidental Injury as may be sustained after the date of reinstatement and loss due to such Illness as may begin more than ten (10) days after that date. In all other respects the Insured and the Company have the same rights under the reinstated policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

F. Suspension of Policy: The benefits and premiums under this Medicare supplement policy can be suspended, at the request of the Policyholder, for a period not to exceed twenty-four (24) months, during which the Policyholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the Policyholder notifies the Company within ninety (90) days after the date of becoming entitled to assistance. If suspension occurs and if the Policyholder loses entitlement to medical assistance, the Policy shall be automatically reinstituted, effective as of the date of termination of entitlement if the Policyholder provides notice of

loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

VI. GENERAL PROVISIONS

A. Time of Effective Date and Termination Date: All dates used in the Policy will begin at 12:01 A.M.

B. Nothing contained in this policy shall in any way or manner restrict or interfere with the right of the Insured to select a Physician.

C. Nothing contained in this policy shall interfere with the relationship between the Physician and the Insured.

D. The Physician shall be free either to decline or to provide care to the Insured in accordance with the custom and practice now prevailing in the private practice of medicine.

E. The Company does not undertake to supply a Physician for the Insured.

F. No person other than the Insured is entitled to receive benefits under this Policy. Such right to benefits is not transferable or assignable. This Policy shall be forfeited if the Insured attempts to transfer its benefits. This Policy shall also be forfeited if the Insured aids or attempts to aid an ineligible person in obtaining any benefits under the Policy.

G. Entire Contract: This policy, including the attached endorsements and papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by an executive officer of the Company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent of the Company has authority to change this Policy or to waive any of its provisions.

H. The Company shall not be liable to the Insured for any Injuries resulting from negligence or malpractice on the part of any officer or employee or on the part of any Physician in the course of rendering services to the Insured.

I. Superseded Plan: This policy supersedes all previous contracts issued by the Company. All such previous policies are hereby canceled. The payment of the Premiums for this Policy by the Insured constitutes an acceptance of this Policy. The Insured waives any and all rights, services, or benefits under any previous policy issued by the Company that accrue after the date of this Policy.

J. Incontestability: After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such two (2) year period.

K. Any notice that is required of the Company shall be deemed to be sufficient if it is mailed to the Insured to the address that appears on the records of the Company. Any notice that is required of the Insured shall be deemed to be sufficient if it is mailed to the principal office of the Company.

L. Medical Records: The Insured consents to and authorizes a Physician or a Hospital to permit the Company to examine and copy any portion of the Insured's medical record that is in connection with the processing of a claim.

M. Legal Actions: No action of law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Policy, 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 to be furnished.

VII. CLAIMS PROVISIONS

Notice of Claim: Written notice of claim must be given to the insurer within six (6) months after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at, WMI Mutual Insurance Company, PO Box 572450, Salt Lake City, UT, 84157, or to any authorized insurance producer of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Furnishing Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Company at the home office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time

required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Time of Payment of Claims: The Insured will receive a notification of the benefit determination within thirty (30) days after the receipt of the claim. If additional information is needed, the Insured or the provider 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.

Recovery of Improper Payment: The Company may recover any amount improperly paid to the Insured or the provider for the following: (i) as the result of a fraudulent insurance act; (ii) within twenty-four (24) months of the amount improperly paid for a coordination of benefits error; (iii) within twelve (12) months of the amount improperly paid for any reason not identified previously; or (iv) within thirty-six (36) months of the amount improperly paid due to a recovery by Medicaid, Medicare, or any other state or federal health care program.

Medicaid Payments: Benefits that are paid on behalf of an Insured will be paid to the human services department when 1) the human services department has paid or is paying benefits on behalf of an Insured person under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, *et. seq.*; 2) payment for the services in question has been made by the human services department to the Medicaid provider; and 3) the issuer is notified that the insured individual receives benefits under the Medicaid program and that benefits must be paid directly to the human services department.

Physical Examination and Autopsy: The Company, at its own expense, shall have the right and opportunity to have the person whose Injury or Illness is the basis of a claim examined when and so often as it may reasonably require during pendancy of claim hereunder. The Company shall also have the right and opportunity to make an autopsy in the case of death where it is not forbidden by law.

Payment of Claims: Any accrued Benefits unpaid at the Insured's death may, at the option of the Company, be paid either to a beneficiary designated by the Insured or to the Insured's estate.

Change of Beneficiary: Unless the Insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured and the consent of the beneficiary shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary, or to any other changes in this Policy.