GROUP HEALTH INSURANCE PLAN CERTIFICATE BOOKLET

(amendments 1-12 incorporated)

MONTANA

1500 (60/45) Plan

(with HDHP endorsement #2 incorporated)
(with amendment #1 to HDHP endorsement #2 incorporated)

WMI Mutual Insurance Company

P.O. Box 572450
(800) 748-5340 (801) 263-8000
FAX (801) 263-1247
Salt Lake City, UT 84157

WMI Mutual Insurance Company

("The Company")

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

Montana Retail Association
Montana Equipment Dealers Association
Montana Tire Dealers Association
Montana Restaurant Association

The Employee named on the Certificate 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 as set forth herein. 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.

All defined terms begin with capital letters.

Schedule of Benefits

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

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

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

HDHP Plan: $1,600

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

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

HDHP Plan: $3,000

(1) 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 has been satisfied.

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

(2) If the optional Prescription Drug benefit has been elected and premiums have been paid, benefits for Prescription Drugs will be paid at the benefit level set forth in the Prescription Drug benefit and subject to the same terms and conditions as major medical expenses. Prescription Drugs costs are applicable to, and subject to, the Individual and Family Annual Maximum Out-of-Pocket amounts. Prescription Drug claims are ineligible for payment at the retail pharmacy and must be submitted directly to the Company for reimbursement.

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

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

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

   (c) **Pre-Deductible Benefit for Eligible Charges for Routine Physical Examinations, Routine Check-ups, and Routine Immunizations:**

   Routine Physical Examinations, Routine Check-ups, and Routine Immunizations covered under this Policy are not subject to the Calendar Year Deductible unless and until the Company has paid a combined 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. **Note: Well-child exams and the first $70 for mammograms are never subject to the Deductible, even if the $500 maximum Benefit for pre-Deductible procedures has been met. The specific Benefits for those services are stated elsewhere in the Schedule of Benefits.**

   (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**): From the moment of birth through two (2) years of age, the Policy covers a history, physical examination, developmental assessment, anticipatory guidance and laboratory tests according to the schedule of visits adopted by the American Academy of Pediatrics. Benefits are limited to one visit payable to one Provider for all of the services provided at each visit in the schedule. Coverage is at the following benefit levels:

   Inside PPO Network: 80%
   Outside PPO Network: 60%

   (2) From two (2) years of age through seven (7) years of age, the Policy covers a history, physical examination, developmental assessment, anticipatory guidance and laboratory tests according to the schedule of visits adopted

by the American Academy of Pediatrics. Benefits are limited to one visit payable to one Provider for all of the services provided at each visit in the schedule, at the following benefit levels (**these services are never subject to the Calendar Year Deductible, even if the $500 maximum Benefit for pre-Deductible procedures has been met**):

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

(3) For children from seven (7) years of age 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: 45%

(4) 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 and influenza immunizations, 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: 45%

(5) Routine childhood immunizations as determined in accordance with the most recent schedule of immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services:

Inside PPO Network: 80%
Outside PPO Network: 60%

(6) 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 section. Category I organ transplants and joint implants must be pre-authorized by the Company in writing. The allowable amount for Implantable Hardware that is used for a joint implant is limited to 300% of the invoice cost, as set forth elsewhere in the Schedule of Benefits. An invoice that shows the actual cost of the implant must be submitted to the Company. Eligible diagnostic, medical and surgical expenses for a compatible live or a cadaveric donor, that are directly related to the transplant, are paid as long as that the recipient of the transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under the coverage of a recipient (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 only considered for benefits after the eligible Employee or Dependent has been insured under the Plan for a period of twelve (12) consecutive months (eighteen (18) consecutive months for a Late Enrollee). 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 **$250,000** per organ. 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. A period of eighteen (18) months must transpire before a benefit shall be allowed for a different eligible Category II organ transplant.

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

(g) **Ambulance services:**

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

(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 (whether internal or external) will be paid at **50%** not to exceed a maximum payment of **$7,500** per Calendar Year.

2. Eligible expenses for insulin pumps (whether internal or external) 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: 45%

of Eligible Charges subject to a maximum Benefit payment of **$2,000** per Calendar Year. The maximum benefit limitation for visits does not apply for treatment rendered within six (6) months of a spinal surgery. This benefit is subject to and eligible to be paid at 100% up to the maximum benefit once the applicable maximum Out-of-Pocket amount is satisfied.

(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**.

(k) **Mammograms:** Subject to the following guidelines, mammograms are payable at **100%** of the first **$70** and thereafter at the levels for all other medical services:

(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.

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

(m) **Sleep Studies.** Eligible expenses are paid to an annual maximum of **$2,000** per Calendar Year and a lifetime maximum of **$4,000.**

(n) **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.

(o) **Colonoscopy:**

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

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.

(p) **Office Visits:**

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

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

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

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

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

HDHP Plan: $3,200

(b) **Annual Family Out-of-Pocket:** The Annual Family Out-of-Pocket amount is equal to two (2) times the Individual Annual Maximum Out-of-Pocket:

HDHP Plan: $6,000

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 Family Out-of-Pocket amount has been satisfied. The Family Out-of-Pocket Amount is an aggregate amount and contributions towards the Family Out-of-Pocket Amount can be made by any covered person.

Only Deductible and co-insurance amounts that are paid by the Insured or Dependent during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Amounts paid for non-covered care or treatment are not applicable toward the Out-of-Pocket maximums. If the optional Prescription Drug benefit has been elected and premiums have been paid, benefits for Prescription Drugs will be paid at the benefit level set forth in the Prescription Drug benefit and subject to the same terms and conditions as major medical expenses. Prescription Drugs costs are applicable to, and subject to, the Individual and Family Annual Maximum Out-of-Pocket amounts. Prescription Drug claims are ineligible for payment at the retail pharmacy and must be submitted directly to the Company for reimbursement.

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

B. **OPTIONAL PRESCRIPTION DRUG BENEFIT:**

There is no Prescription Drug Benefit unless the optional Prescription Drug Card Rider has been elected and premiums have been paid. Eligible Prescription Drugs are payable at the benefit level set forth below subject to the same terms and conditions of the applicable major medical Deductible and applicable maximum Out-of-Pocket amounts. Prescription Drug claims are ineligible for payment at the retail pharmacy and must be submitted directly to the Company for reimbursement. An Insured shall only pay the required copayment or coinsurance, after the deductible, for a covered Prescription Drug at the time of purchase if the Prescription Drug dispenser or the Company can determine that amount at the time of purchase. If the optional Prescription Drug Benefit 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:**

HDHP Plan: Included in Major Medical Deductible

2. **Prescription Drug Co-Pay:**

Generic: 25%
Brand: 50%

3. **Annual Prescription Drug Maximum:**

HDHP Plan: $50,000

C. **MENTAL ILLNESS CARE, TREATMENT OF ALCOHOL AND SUBSTANCE ABUSE, 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 treatment for non-Severe Mental Illness:** Inpatient treatment for Mental Illness may be traded on a 2-for-1 basis for a Benefit for partial hospitalization through a program that complies with the standards for partial hospitalization that are published by the American association for partial hospitalization if the program is operated by a Hospital.

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

(2) **Outpatient treatment for non-Severe Mental Illness:**

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

(3) **Inpatient and Outpatient treatment for Severe Mental Illness:**

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

(4) **Inpatient and outpatient treatment for alcoholism and drug addiction:**

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

(5) **Medical detoxification:** Subject to the terms and limitations as set forth in this Schedule of Benefits and the Policy as for any other illness and not subject to the annual and lifetime maximums for inpatient and outpatient treatment for alcoholism and drug addiction.

D. **MENTAL ILLNESS CARE, TREATMENT OF ALCOHOL AND SUBSTANCE ABUSE, AND DETOXIFICATION SERVICES (for Employers with 51 or more Employees):**

The following 2 options are available. Please contact the Company's office to determine which option has been selected by the Policyholder.

Option I (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 treatment for Severe and non-Severe Mental Illness Care:**

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

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

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

3. **Medical detoxification:** Subject to the terms and limitations as set forth in this Schedule of Benefits and the Policy as for any other illness and not subject to the annual and lifetime maximums for inpatient and outpatient treatment for alcoholism and drug addiction.

Option II*:

No Benefits are available for Severe and non-Severe Mental Illness Care, Treatment of Alcohol and Substance Abuse, or Detoxification Services. If Option II is selected by the Policyholder, all Benefits for Mental Illness services and alcohol and substance abuse services are excluded from coverage. Any amounts paid by the Insured for these services are not applicable to the Deductible or the Out-of-Pocket amounts.

*Note: If the Plan II option is chosen by the Policyholder, there are no Benefits available for Prescription Drugs for any psychotherapeutic agents or Prescription Drugs for the treatment of Alcohol and Substance Abuse,

even if the optional Prescription Drug card rider has been elected and premiums for the optional rider have been paid.

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I. 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 caused by an external force, a foreign body, or corrosive chemical, that is independent of disease or bodily infirmity and for which the Insured is not entitled to receive any Benefits under any workers' compensation or occupational disease law. Physical damage resulting from normal body movement such as stooping, bending, twisting, or chewing is not considered an Accident.

"Actively at Work" and **"Active Work"** means being in attendance in person at the usual and 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 that 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 Treatment Center" means a treatment facility that provides a program for the treatment of alcoholism or drug addiction pursuant to a written treatment

plan approved and monitored by a Physician or an addiction counselor certified by the state, and is licensed or approved as a treatment center by the Department of Public Health and Human Services.

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

“Company” means the WMI Mutual Insurance Company.

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

“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 coverage of the individual under any of the following:

1) A group health benefit plan;
2) Health insurance coverage;
3) Title XVIII, part A or Part B of the Social Security Act (Medicare);
4) Title XIX of the Social Security Act (Medicaid);
5) Title 10, Chapter 55, United States Code (medical care and dental care for members and certain former members of the uniformed services and their dependents);
6) A medical care program of the Indian Health Services or of a tribal organization;
7) The Montana comprehensive health association;
8) A health plan offered under Title 5, Chapter 89, United States Code (Federal Employees Health Benefits Program (FEHBP));
9) A public health plan;
10) A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. 2504 (e)); or
11) A high-risk pool in any state.

Plan participants will be given “credit” toward the satisfaction of any Preexisting Condition Limitation period for the length of coverage under any of the above listed 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 sixty-three (63) days or more during all of which the individual was not covered under any Creditable Coverage. This sixty-three (63) 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. The sixty-three (63) day period will be counted from the date that the certificate of creditable coverage was issued to the individual, which must be no later than ten (10) days after the termination of coverage.

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

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

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

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

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

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

"Date Incurred" means the date services were provided.

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

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

(a) The lawful spouse of an Insured Employee.

(b) The Insured Employee's (or the Insured Employee's Spouse's) unmarried Child(ren) under twenty-five (25) years of age who is:

i) not an employee eligible for coverage under a group health plan offered by the Child's employer for which the Child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan;
ii) not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan or group health insurance;
iii) not entitled to benefits under 42 U.S.C. 1395, *et.seq.*; and
iv) for whom the parent has requested coverage.

(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; and

(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, means the date the Employer’s Plan becomes in force. As pertains to the Employee or Dependent, the term “Effective Date” shall mean the date the Employee or Dependent becomes Insured.

“Eligible Charges” means those charges incurred by an Insured Employee or Insured Dependent for which coverage is available under the terms and conditions of the Policy. Eligible Charges for PPO expenses are based on negotiated fee schedules; Eligible Charges for non-PPO expenses are based on the Usual and Customary rate as determined by the Company.

“Emergency” means a sudden change in a patient’s condition such that immediate medical or surgical intervention is required and the absence of such intervention could be expected to result in imminent deterioration of health, permanent physical harm or death.

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

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

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

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

“High Deductible Health Plan” or “HDHP” means a health plan: (1) that has an annual deductible which is not less than: (a) $1,000 for self-only coverage (as indexed by federal law), and (b) twice the dollar amount in subclause (1)(a) for family coverage; and (2) the sum of the annual deductible and the other annual out-of pocket expenses

required to be paid under the plan (other than for premiums) for covered benefits does not exceed: (a) $5,000 for self-only coverage (as indexed by federal law), and (b) twice the dollar amount in subclause (2)(a) for family coverage. The definition of a High Deductible Health Plan or an HDHP is subject to the requirements of Internal Revenue Code §223(c)(2).

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

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

(a) Is engaged in providing nursing services and other medical services under the supervision of a Physician;

(b) Maintains a complete medical record on each patient;

(c) Is not engaged in providing Custodial Care, care or treatment of Mental Illness, or care or treatment for drug or alcohol abuse or dependency; and

(d) Qualifies as a reimbursable service under Medicare.

"Hospital" means a facility which is licensed and accredited by the Joint Commission on Accreditation of Hospitals 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. With respect to "obstetrical deliveries or sterilization", Illness means the bodily condition which permits obstetrical delivery, or sterilization.

"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" for which Benefits are provided, 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 workers' 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.

"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 (Medical Necessity)" means health care services that a health care Provider who exercises prudent clinical judgment would provide to a patient. Such services must be provided to prevent, to evaluate, to diagnose, to treat, to cure, or to relieve a health condition, an Illness, an Injury, or a disease or its symptoms. Such services must be all of the following.

They are in accordance with the generally accepted standards of practice.

They are clinically appropriate in terms of the type, the frequency, the extent, the site, and the duration. They are considered effective for the Illness, the Injury or the disease of the patient.

They are not primarily for the convenience of the patient or the health care Provider. They are not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Illness, the Injury, or the disease of the patient.

"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 a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress or a painful symptom, a disability or impairment in one or more areas of functioning, or a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. Mental Illness does not include a development disorder; a speech disorder; a psychoactive substance use disorder; an eating disorder, except for bulimia and anorexia nervosa; an impulse control disorder, except for intermittent explosive disorder and trichotillomania; or a Severe Mental Illness as defined in this Policy.

"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. Only Deductible and eligible co-insurance amounts

that are paid by the Insured during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. 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 optional 24-hour coverage, an Owner must be one who is not required by law to be covered by workers' compensation insurance, and who has no such insurance in effect.

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

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

"Policyholder" means the Employer named on the Certificate.

"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 confinement is Medically Necessary and that the proposed length of stay is appropriate. **Pre-certification does not guarantee payment or determine Benefit eligibility.** Although recommended, Pre-certification for Urgent Care is **not** required. However, once the care is no longer Urgent Care, Pre-certification requirements will apply. Pre-certification is also recommended, but **not** required, for Severe and non-Severe Mental Illness, alcoholism, drug addiction, reconstructive breast surgery, and maternity delivery services that are within the federally allowed time limits.

"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 six (6) months prior to the Enrollment Date. The term "Preexisting Condition" does not include pregnancy and does not include genetic information in the absence of a diagnosis of the condition related to such information.

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

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

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

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

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

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

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

(a) Resident beds or residential units;

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

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

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

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

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

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

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

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

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

"Severe Mental Illness" means the following disorders as defined by the American Psychiatric Association: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.

"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.

"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 that is associated with a medical or a surgical supply, a service, a procedure or a prescription drug that is used to calculate the eligible allowance for a non-preferred provider. This charge represents the normal charge level at the 70th percentile for that procedure in the geographic area of service. Usual and Customary allowances are derived from a national database that is updated at least annually. The geographic area of service is determined by the number of similar providers in a zip code range. For the purpose of air Ambulance services, the Usual and Customary amount shall be limited to 250% of the amount that is allowed by Medicare.

"Waiting Period" means the time between the Employee's date of hire and the date the Employee begins participation in the Plan.

II. ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE:

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

A. **ELIGIBILITY DATE FOR EMPLOYEES OF NEWLY ENROLLED EMPLOYER GROUPS:**

Employees who worked an average of twenty (20) hours or more per week during the preceding month are eligible to participate in the Plan on the Effective Date of the Employer's Plan. Employees must enroll in the Plan prior to the Employer's Effective Date. In order to enroll, Employees must submit a properly completed enrollment card to the Company. Any eligible Employee who does not enroll prior to the Effective Date of the Employer's Plan, is ineligible to enroll in the Plan until the next Open Enrollment period.

B. **ELIGIBILTY 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 the later of the following events:

1. The satisfaction of the Employer's eligibility requirements and Waiting Period.

2. Their date of hire (if they maintained other health insurance coverage as of their date of hire).

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).

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

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

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

C. **ELIGIBILITY DATE FOR DEPENDENT(S):**

Eligible Dependents must submit a properly completed enrollment card to the Company to enroll in the Plan. Eligible Dependents who enroll at the same time as the Employee are eligible to participate in this Plan on the same day as the Employee. An eligible Dependent who does not enroll at the same time as the eligible Employee is ineligible to enroll in the Plan until the next Open Enrollment period.

D. **SPECIAL ENROLLEES:**

The following individuals are eligible to enroll in the Plan outside the Open Enrollment period, provided that a properly completed written enrollment card is submitted to the Company within thirty-one (31) days of eligibility. Coverage will be effective on the first day of the first calendar month following the date that the enrollment materials are received by the Company.

1. Employees who declined participation in the Plan when they were first eligible because they maintained other health insurance and have since lost the other coverage. If the other coverage is provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Employee may only enroll after the COBRA coverage has been exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, coverage through this Plan must be requested within sixty (60) days after the termination. An individual who voluntarily cancels other health coverage or ceases to pay premiums for such other coverage is not eligible for special enrollment rights and must wait until the Open Enrollment period to enroll.

2. Employees who marry or acquire a Child through birth, adoption, or placement for the purpose of adoption.

3. Eligible Dependents of Employees Insured under the Plan, when the eligible Dependent declined participation in the Plan when the Dependent was first eligible because other health insurance was maintained and the Dependent has since lost the other coverage. If the other coverage is COBRA coverage, the Dependent may only enroll after the COBRA coverage has been exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, coverage through this Plan must be requested within sixty (60) days after the termination. An individual who voluntarily cancels other health coverage or ceases to pay premiums for such other coverage is not eligible for special enrollment rights and must wait until the Open Enrollment period to enroll.

4. Eligible Dependents of Insured Employees acquired due to marriage, birth, adoption, or placement for the purpose of adoption, are subject to the following eligibility rules:

    (a) A spouse may enroll in the Plan at the time of marriage or when a Child is born, adopted or placed for the purpose of adoption.

    (b) Any newborn infant of any covered person is automatically covered, with no waiting or elimination period, from the moment of birth for a period of thirty-one (31) days. Coverage for a newborn infant includes immediate accident and sickness coverage, from and after the moment of birth. An adopted Child is automatically covered from the date the Child is placed for the purpose of adoption and will continue unless the placement is disrupted prior to legal adoption. Coverage at the time of placement includes the necessary care and treatment of medical conditions existing prior to the date of placement.

        Coverage can only be extended beyond the thirty-one (31) day period for an eligible Dependent Child(ren) as that term is defined in the Policy. If the payment of a specific premium is required to provide coverage for a newborn Child or adopted Child who qualifies as a Dependent under the terms and conditions of this Plan, the Insured Employee must enroll the eligible Child within thirty-one (31) days from the date of birth or placement for adoption and must pay all applicable premium within the thirty-one (31)

day period, in order for the coverage of a newborn Child or a Child placed for the purpose of adoption to extend beyond the thirty-one (31) 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 ELIGIBILITY:**

Active Employees are eligible to participate in the Plan as long as they are Actively at Work in the regular business of an Employer. Active Employees must work an average of at least eighty (80) hours per month while receiving compensation for such service from the Employer. Eligibility may also be maintained if the Employee is on paid leave status of not more than six (6) months and if he worked an average of eighty (80) hours during the two (2) months immediately preceding the date he was placed on leave status.

F. **ALTERNATE RECIPIENTS:** An alternate recipient is a child of an Employee who is recognized under a qualified medical child support order ("QMCSO") as having a right to enrollment under a group health plan with respect to such Employee, outside of the Open Enrollment period. If the medical child support order is determined by the Company to be a "qualified" order, the effective date of the alternate recipient's coverage will be the first day of the first month following the date of determination. A copy of the Plan's QMSCO procedures may be obtained free of charge, upon request.

III. 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 timely received by the Company, coverage will be automatically 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 the Plan may be immediately terminated if the Employee has performed an act or practice that constitutes fraud. An Employee's insurance under the Plan may also be terminated if he has made an intentional misrepresentation of material fact under the terms of the coverage. 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 the Plan may be immediately terminated if the Dependent has performed an act or practice that constitutes fraud. A Dependent's insurance may also be terminated if he has made an intentional misrepresentation of material fact under the terms of the coverage. In addition, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

C. **EXCEPTIONS TO THE TERMINATION OF DEPENDENT COVERAGE PROVISIONS:**

1. In the event of the Employee's death, the coverage with respect to each of his Dependent(s) shall be continued in force until the last day of the month for which the premium was paid.

2. A Dependent Spouse may remain on the Plan for up to thirty-six (36) months when the Employee becomes insured under Medicare.

3. If an Employee's covered Dependent(s) is incapable of self-support because of mental retardation or physical handicap on the date his coverage would otherwise terminate on account of age and within 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 31st day after the Company requests additional proof of his incapacity if the Employee fails to furnish such proof;

   (c) The last day in which premiums have been paid.

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

A. **INPATIENT FACILITY SERVICES:** The Medical Necessity of the length of stay of all Inpatient facility confinements must be Pre-Certified. Pre-certification is recommended for Urgent Care but it is **not** required. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. Pre-certification is also recommended, but **not** required, for Severe and non-Severe Mental Illness, alcoholism, drug addiction, reconstructive breast surgery, and maternity delivery services that are within the federally allowed time limits. The company that must be contacted for Pre-certification is shown on the insurance card. They must be contacted before all Inpatient facility admissions that are not emergencies. 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 confinement by 10%. **Pre-certification does not guarantee that payment will be made nor does it determine that Benefits are eligible.** If an Insured receives an adverse Pre-certification determination in which Benefits are denied in whole or in part, he may contact the Company to request a review, 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 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. 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. Covered 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 Non-Severe Mental Illness Care. Eligible expenses are covered 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.

5. Inpatient Alcoholism and Drug Addiction Treatment. Eligible expenses are covered as set forth in the Schedule of Benefits. Care must be rendered in a Chemical Dependency Treatment Facility as defined in the Policy in order to be eligible for Benefits and must also meet all other criteria for eligibility subject to all other terms and provisions of the Policy in order for Benefits to be provided.

6. Inpatient Extended Care Facility/Rehabilitation Care Facility. The eligible amount for the daily room charge that is incurred at an Extended Care or Rehabilitation Care Facility is limited. It is limited to the most common daily charge for a Semi-private room that is charged by such facility. All other Covered Expenses will be paid in accordance with the Policy guidelines. The Benefit for an Extended Care Facility or Rehabilitation Care Facility is limited. It is limited to a maximum of sixty (60) days in each Calendar Year. Custodial Care is not considered to be Extended Care or Rehabilitation Care and it is not eligible for Benefits.

7. Inpatient Severe Mental Illness Care. Subject to the same terms and limitations as care for other physical illness. Care must be rendered in a Mental Health Care Facility as defined in the Policy in order to be eligible for Benefits. Treatment rendered in a Mental Health Care Facility must also meet all other criteria for eligibility subject to all other terms and provisions of the Policy in order for Benefits to be provided.

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

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

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

1. One surgical assistant is covered for each surgery. The services of a surgical assistant are only covered if they are Medically Necessary. Payment is limited to 20% of the amount 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.

E. **MEDICAL SERVICES:**

1. Physician Consultations:

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

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

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

   (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 an 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 immunizations as set forth in the Schedule of Benefits.

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

5. The Plan covers: 1) all stages of reconstruction of the breast on which a mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of a mastectomy, including lymphedemas. Treatment must be determined in consultation with the attending Physician and the patient.

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

   "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty, and mastopexy.

   Benefits for reconstructive breast surgery include benefits for outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer.

F. **HOSPICE CARE:** All services provided by a Hospice if: (a) the charge is Incurred by an Insured person diagnosed by a doctor as terminally ill with a prognosis of six months or less to live; and (b) the Hospice provides a Plan of care which: (i) is prescribed by the doctor; (ii) is reviewed and approved by the doctor monthly; (iii) is not for any curative treatment; (iv) states the belief of the doctor and the Hospice that the Hospice care will cost less in total than any comparable alternative to Hospice care; and (v) is furnished to the Company.

   Hospice care includes: (a) services and supplies furnished by a Home Health agency or licensed Hospice, including Custodial Care; (b) confinement in a Hospice as long as charges do not exceed 150% of the average Semi-Private room daily rate in short term Hospitals in the area in which the Hospice is located; and (c) palliative and supportive medical and nursing services.

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

   1. Organ Transplants and Joint Implants are covered as set forth in the Schedule of Benefits. All such services must be pre-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; (iii) lung (single or double); (iv) pancreas; and (v) bone marrow, stem cell rescue, stem cell recovery, any and all other procedures involving bone marrow or bone marrow components as an adjunct to high dose chemotherapy, including services related to any evaluation, treatment or therapy involving the use of myeloablative chemotherapy with autologous hematopoietic stem cell and/or colony stimulating factor support (MC-AHSC/CSF).

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

All organs for Category I and Category II transplants must be natural body organs. No Benefits are available for any artificial organs or any mechanical-electronic organs of any type other than intra-ocular lens implants and artificial joint implants.

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

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

I. **ANESTHESIA SERVICES:** The Plan covers anesthesia service to achieve general or regional (but not local) anesthesia. This service must be at the request of the attending Physician and performed by a Physician other than the operating Physician or the assistant. Services of a nurse anesthetist who is not employed by the Hospital and who bills for services provided are also covered. Services of a nurse anesthetist are covered only if they are Medically Necessary and if a Hospital employee or Physician is unavailable.

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

K. **MATERNITY SERVICES:**

1. Maternity Benefits are paid on a female Employee or female Dependent 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 and newborn Child to less that forty-eight (48) hours following a 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. Although not required, it is recommended that the expectant mother call the Precertification 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. Any newborn infant of any covered person is automatically covered, with no waiting or elimination period, from the moment of birth for a period of thirty-one (31) days. In order for the coverage of a newborn Child who qualifies as a Dependent under the terms and conditions of this Plan to extend beyond the thirty-one (31) day period, the Insured Employee must enroll the Child within thirty-one (31) days from the date of birth.

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

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

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

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

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

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

5. Physical therapy that is rendered by a Provider operating within the scope of their license is covered. Physical therapy must be Medically Necessary and is subject to all other Policy provisions. Physical therapy administered to the back and spine is only covered under the provision for back and spine manipulations and modalities.

6. Back and spine manipulations and modalities are covered as set forth in the Schedule of Benefits.

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

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

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

happened prior to the Effective Date of coverage will be subject to the Preexisting Condition limitation.

10. Home Health Care is covered for a period not to exceed ninety (90) Visits in any one Calendar Year. One (1) four (4) hour Visit is allowed per day. Home Health Care must be provided by a licensed home health agency, in the Insured's place of residence, and must be prescribed by the Insured's attending Physician. Services provided for Home Health Care include:

    (a) Nursing;

    (b) Home health aide services;

    (c) Physical therapy;

    (d) Occupational therapy;

    (e) Speech therapy;

    (f) Hospice service;

    (g) Medical supplies and equipment suitable for use in the home; and

    (h) Medically necessary personal hygiene, grooming, and dietary assistance.

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

12. Cardiac rehabilitation therapy, such as, but not limited to, use of common exercise equipment while under a Physician's care. The therapy must take place in a formal rehabilitation program at an accredited facility, and must be prescribed by a Physician. This Benefit is limited to a maximum of $500 per occurrence. Therapy must be rendered within ninety (90) days following cardiac Illness or surgery in order to be eligible.

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

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

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

16. Treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage includes expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment

including clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and enterally administered medical foods.

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 reestablish 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") provided that the optional Prescription Drug Benefit has been elected and premiums have been paid. Prescription Drugs purchased through the optional Prescription Drug Benefit apply to the Major Medical Deductible and the Out-of-Pocket yearly maximum. In accordance with the Policy provisions for determining medical necessity, some Prescription drugs are subject to maximum dispensing limitations at either a retail pharmacy or through the mail order program. These limits are based on clinically approved prescribing guidelines and are regularly reviewed to ensure medical necessity and appropriateness or care. Prescription Drugs that exceed the manufacturer's recommended dosage or the dosage established by the Food and Drug Administration ("FDA") are not covered. There are no Benefits for Prescription Drugs if the Optional Prescription Drug Benefit 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. This Benefit is payable as set forth in the Schedule of Benefits. Treatment to diagnose and to correct snoring is not covered.

20. Therapy for pulmonary rehabilitation is covered while under a Physician's care. The therapy must take place in a formal rehabilitation program at an accredited facility, and must be prescribed by a Physician. This benefit is limited to a maximum of $500 per occurrence. Therapy must be provided within the ninety (90) days following the diagnosis of pulmonary illness or surgery in order to be eligible.

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

22. Expenses for devices for contraception, including treatment or services rendered in connection with placement of such devices are covered. Expenses for Prescription Drugs for contraception are eligible for Benefits only if the optional Prescription Drug Benefit has been elected and premiums for the optional Benefit have been paid.

23. Expenses related to diagnosis, monitoring, treatment, control, and education for self-management of diabetes. Coverage is limited to insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States Food and Drug Administration, and glucagon emergency kits. Coverage also includes a **$250** Benefit per person per Calendar Year for Medically Necessary and prescribed outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes. Annual co-insurance and Deductible provisions are subject to the same terms and conditions applicable to all other covered Benefits within a given Policy, as set forth in the Schedule of Benefits section A(2)(a&b). **Note:** Eligible Benefits for insulin pumps are limited to one insulin pump per warranty period, and will be based on the most appropriate and Medically Necessary pump that is available. Although not required, it is recommended that the Insured obtain Pre-certification from the Company prior to purchasing a pump in order to determine the Eligible Benefits before charges are incurred.

24. 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.

25. Prescription vitamins (including prenatal and pediatric vitamins), in single or in combination form; prescription calcium supplements; and prescription hematinics. Coverage is available for injectable and non-injectable forms. Benefits are only available if the optional Prescription Drug Card rider has been elected and premiums have been paid.

26. Eligible expenses for acupuncture or acupressure are payable at **50%** to a maximum payable amount of **$100** per Calendar Year.

27. Expenses for the diagnosis and treatment of autistic disorder, Asperger's disorder, or a pervasive developmental disorder not otherwise specified as defined by the Diagnostic and Statistical Manual of Mental Disorders. Benefits are limited to **$50,000** per Calendar Year for Children eight (8) years of age and younger, and **$20,000** per Calendar Year for Children nine (9) years of age through eighteen (18) years of age. Coverage includes the following:

    (a) habilitative or rehabilitative care that is prescribed, provided or ordered by a licensed Physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the Child;
    (b) medications prescribed by a Physician;
    (c) psychiatric or psychological care; and
    (d) therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

    Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention. Applied behavior analysis covered under this section must be provided by an individual who is licensed by the behavioral analyst certification board or is certified by the department of public health and human services as a family support specialist with an autism endorsement.

    The Company may request that the treating Physician provide a written treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reason that the treatment is medically necessary.

    For the purposes of this provision, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician or psychologist licensed in this state and that will or is reasonably expected to: 1) prevent the onset of an Illness, condition, Injury, or Disability; 2) reduce or improve the physical, mental, or developmental effects of an Illness, condition, Injury, or Disability; or 3) assist in achieving maximum functional capacity in performing daily activities.

28. Expenses for the diagnosis and the treatment of Down syndrome are covered. Benefits are limited to Children through eighteen (18) years of age. Coverage includes the services that are listed below.

    (a) Habilitative care or rehabilitative care that is prescribed by, that is provided by or that is ordered by a licensed Physician. This includes, but it is not limited to, professional, counseling, and guidance services and

treatment programs. These programs must be medically necessary to develop and to restore, to the maximum extent that is practicable, the Child being able to function.

(b) Therapeutic care that is medically necessary and that is provided as follows.

(1) Up to 104 sessions per year with a speech-language pathologist who is licensed.
(2) Up to 52 sessions per year with a physical therapist who is licensed.
(3) Up to 52 sessions per year with an occupational therapist who is licensed.

Medically necessary interactive therapies are included in this type of care. These therapies are derived from research that is based on evidence. Intensive intervention programs are included in these therapies. Early intensive behavioral intervention is also included in these therapies.

Applied behavior analysis that is covered under this section must be provided by an individual who is licensed. This individual must be licensed by the behavioral analyst certification board. Applied behavioral analysis may also be provided by an individual who is certified by the department of public health and human services. This individual must be certified as a family support specialist with an endorsement in autism.

When treatment is expected to require services that will continue, the Company may request that the treating Physician provide a written treatment plan. The treatment plan must consist of the diagnosis, the proposed treatment by type and by frequency, the anticipated duration of the treatment, the anticipated outcomes stated as goals, and the reason that the treatment is medically necessary. The treatment plan must be based on screening criteria that is based on evidence. The Company may request that the treatment plan be updated every 6 months.

For the purposes of this provision, “medically necessary” means any care, treatment, intervention, service, or item that is prescribed by, that is provided by, or that is ordered by a Physician who is licensed in this state. Such care, treatment, intervention, service or item must do, or is reasonably expected to do, any of the following.

a) It will reduce or it will improve the physical, the mental, or the developmental effects of Down syndrome.
b) It will assist in the maximum functional capacity being achieved in the performance of daily activities. This must take into account both the functional capacity of the Child and the functional capacities that are appropriate for a child of the same age.

V. 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 for which payment has been made under any automobile or vehicle medical payment provisions 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. This provision only applies in situations involving first-party liability. Situations involving third-party liability are governed according to the subrogation provisions as set forth elsewhere in this Policy in the section titled "Third Party Liability".

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: riot; war; an act of war while in military, naval, or air services of any country at war; 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.

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. This exclusion also does not apply when expenses are incurred for reconstructive surgery after a mastectomy. The Preexisting Condition limitation applies to any exception to this general exclusion as set forth herein.

11. Expenses for treatment of obesity or for weight reduction. This exclusion includes, but is not limited to: stomach stapling; gastric bypass; balloon implant; similar

surgical procedure; and Prescription Drugs for the purpose of weight loss or weight control.

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

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

16. Expenses made which are in excess of Usual and Customary allowances.

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

21. 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.

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

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

24. Expenses for rest cures.

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

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

27. Expenses 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.

28. 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".)

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 an Illness or Injury that is the result of the Insured voluntarily taking action that leads to the Illness or Injury by using or abusing any illegal drug; for Injuries sustained as a result of the Insured voluntarily taking action that leads to the Injury by operating a motor vehicle while exceeding the legal limit of intoxication; and for Injuries sustained as a result of the Insured voluntarily taking action that leads to the Injury by abusing Prescription Drugs not taken in accordance with a Physician's Prescription Order. However, this exclusion will be waived and the Company will pay a maximum amount of **$50,000** for each occurrence **if** eligible care and treatment is provided as the result of an Accident or Injury.

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

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

    (a) Medically Necessary.

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

33. Expenses for training, educating, or counseling a patient. This exclusion does not apply when such services are incidentally provided (without a separate expense) in connection with other Covered Services, 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, unless otherwise specified in the Policy. 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 Illness or the date of Injury. The Preexisting Condition limitation applies to the exception to this general exclusion.

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

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

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

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

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

38. Expenses for: (i) Routine Physical Examinations for Insureds which exceed the guidelines set forth in this Policy or the Schedule of Benefits; (ii) x-ray or laboratory procedures when there are no symptoms of Illness or Injury, unless they are covered as part of the Routine Physical Examination Benefit; or (iii) mental examinations or psychological tests when there are no symptoms of Mental Illness. This exclusion does not apply to expenses that are specifically set forth in the Schedule of Benefits or to mandated benefits.

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

40. Expenses for appointments scheduled and not kept.

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

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

    If surgical treatment for such procedures is deemed to be Medically Necessary and is in accordance with accepted medical practice as determined by the Company, Benefits will be allowed at **50%** up to a maximum benefit of $1,000 per Calendar Year**.** The treatment plan must be specifically authorized in writing by the Company prior to surgery.

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

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

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

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

48. Expenses for:

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

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

    (c) Treatment (including cutting or removal by any method) of toenails (other than the removal of the nail matrix or root), corns, or calluses.

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

50. Expenses for services provided by an immediate relative of the Insured or by an individual who customarily lives in the same household with the Insured.

51. Expenses for radioallergosorbent (“RAST”) testing.

52. Expenses for preventative medication, non-prescription vitamins, mineral and nutrient supplements, fluoride supplements, food supplements, sports therapy equipment, and the services and applications of such. This exclusion does not apply to Prescription Drugs for contraception, which are covered elsewhere in the Policy.

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

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

55. Expenses for experimental drugs; non-legend drugs; smoking deterrents; anti-wrinkle agents; and Tretinoin, all dosage forms (for example, Retin A) for Insureds of twenty-five (25) years of age.

56. Medicines that, by a law of the United States, require a Physician's Prescription. This exclusion does not apply if the optional Prescription Drug Benefit has been elected and premiums have been paid.

57. Expenses for autopsy procedures.

58. 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 that are designed to help or treat infertility.

59. Expenses for care of elective surgery; complications of elective surgery; or complications of an ineligible procedure.

60. Expenses for circumcisions that are not performed within thirty (30) days of birth or adoption.
61. Expenses that are related to treatment for infertility including Prescription Drugs and medications.

62. Expenses for massage therapy.

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

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

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

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

67. Drugs and medicines not requiring a Prescription Drug Order, such as over-the-counter medications.

VI. PREEXISTING CONDITIONS AND ELECTIVE SURGERY LIMITATIONS:

A. TWELVE MONTH LIMITATION:

During the twelve (12) months (eighteen (18) months for a Late Enrollee) following the Enrollment Date, no Benefits will be provided under this agreement for any of the following:

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 twelve (12) months (eighteen (18) months for Late Enrollees) following the Enrollment Date of the individual's coverage due to a Preexisting Condition.

The twelve (12) month Preexisting Condition limitation (eighteen (18) months for Late Enrollees) will be reduced by the number of days of Creditable Coverage calculated as of the Enrollment Date of the Insured.

2. Revision or reversal of a surgical procedure which would be covered under the terms of the Policy, but which was performed prior to the Enrollment Date. This limitation applies whether such services are due to Illness or Injury, however, this time period will be reduced by the number of days of Creditable Coverage calculated as of the Enrollment Date of the Insured.

VII. COBRA, USERRA, CONVERSION, AND COVERAGE DURING DISABILITY:

A. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"):

If the Insured's Employer employs more than 20 Employees on an average business day during the previous Calendar Year, federal law provides that the Employee and/or his Dependents may be entitled to continue insurance Benefits after termination of group health benefits upon a qualifying event for a period of up to thirty-six (36) months. Some states also require employers with fewer than 20 employees to offer to the insured individuals continuation of their group health coverage. Your Employer can provide you with complete details of the available coverage. WMI Mutual Insurance Company does not assume responsibility for the Employer's duties under COBRA.

COBRA continuation coverage is available upon the occurrence of any of the following qualifying events:

1. Termination of employment.
2. Reduction of hours.
3. Death of employee.
4. Employee becomes entitled to Medicare benefits.
5. Divorce or legal separation.
6. Dependent child ceases to be a dependent under the Plan.

In the case of divorce, legal separation, or a dependent ceasing to be a dependent, it is the responsibility of the employee to notify the Employer in writing within 60 days of the qualifying event, and to send a copy of the notice to the Company. Election of the continuation coverage must be in writing within 60 days after the employer sends notice of the right to elect continuation coverage. If election is not made within this 60 day period, the Employee and/or any qualified Dependents will lose the right to COBRA continuation coverage.

When COBRA coverage is available, any person who was on the insurance before termination has the right to select COBRA coverage independently. A newborn

Child or a Child placed for adoption during a period of COBRA continuation coverage is also eligible for coverage for the remaining period of 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 are 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. **Conversion Plan:**

If the insurance or any portion of the insurance on an Employee or the Employee's Dependents covered under the Policy ceases 1) because of termination of the Employee's membership in a group eligible for coverage under the Policy; 2) because of termination of the Employee's employment; 3) as a result of the Employee's Employer discontinuing the business; or 4) as a result of the Employee's Employer discontinuing the group disability insurance Policy and not providing for any other group disability insurance or plan, the Employee or the Employee's Dependents are entitled to have issued, without evidence of insurability, the Company's conversion plan. The Employee or the Employee's Dependents must have been insured for a period of three (3) months and must not be insured under another major medical disability insurance policy or plan to be eligible for the conversion plan.

If the Insured exercises this conversion option, he may waive his right to purchase a guarantee-issued individual policy of health insurance under the federal Health Insurance Portability and Accountability Act of 1996. (P.L. 104-191).

The right to be covered under the Company's conversion plan is also available:

1. To the surviving Spouse, if any, at the death of the Employee, with respect to the Spouse and Children whose coverage under the group Policy terminates by reason of the death, otherwise to each surviving Child whose coverage under the group Policy terminates by reason of the death

2. To the Spouse of the Employee upon termination of the coverage of the Spouse by reason of ceasing to be a qualified Dependent under the group Policy, including Children whose coverage under the group Policy terminates at the same time.

3. To a Child solely with respect to the Child upon termination of the Child's coverage by reason of ceasing to be a qualified Dependent under the group Policy.

An individual does not have conversion rights if:

1. Termination of the group coverage occurred because of failure of the Employee to pay a required individual premiums;
2. The Insured acquires other group health coverage that is comparable to the coverage under the conversion plan;
3. The Insured has performed and act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact under the terms of the coverage.

An individual who purchases a conversion plan ceases to be eligible for a conversion plan if the individual 1) fails to pay the premium on the conversion plan; or 2) enrolls under another major medical disability policy or plan, except that the individual may maintain the conversion policy during any waiting period established under any new disability policy or plan that the individual purchases.

Written application for the conversion plan must be made, and the first premium must be tendered, to the Company within thirty-one (31) days after the termination of the group coverage.

D. **Coverage During Periods of Disability:**

The Company must be notified in writing within thirty (30) days of the date of Disability for this provision to apply.

1. Disability related Expenses: In the event the group Policy terminates for any reason while Benefits are being paid and it is established that:

   (a) The Insured or Dependent(s) was totally Disabled when such insurance terminated; and

   (b) Expenses were incurred in connection with the Accident or Illness causing such Total Disability; and

   (c) The total Maximum Amount of Benefits have not been paid,

Benefits with respect to expenses incurred in connection with the Injury or Illness causing such Disability will be continued during such Total Disability until the earliest of: (i) twelve (12) months from the date on which insurance terminated; (ii) until the total maximum amount of Benefits has been paid; (iii) the Employee or Dependent(s) ceases to be totally Disabled; (iv) the Disabled person becomes Insured or Covered under any other group medical benefit or service plan or self-funded plan, including the Conversion Plan of this Company.

VIII. COORDINATION OF BENEFITS, THIRD PARTY LIABILITY AND PERSONS COVERED BY MEDICARE:

A. COORDINATION OF BENEFITS:

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with 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.

DEFINITIONS

A. A plan is any of the following that provides benefits or services for medical care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); 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.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, if determined by the commissioner to be "excepted benefits" as defined in Montana law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if

the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

B. (1) Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the certificateholder is a secondary plan. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

D. Each plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent 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 a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber 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; or

- 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 not living together, whether or not they have ever been married:

(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 primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

(ii) 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 (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (a) above shall determine the order of benefits; or

(iv) 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 child are as follows:

- The plan covering the **Custodial parent**;

- The plan covering the spouse of the **Custodial parent**;

- The plan covering the **non-custodial parent**; and then

- The plan covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the 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, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plan**s** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by 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 COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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

1. Recovery Rights: To the extent necessary for reimbursement of Benefits paid to or on behalf of the Insured, the Company is entitled to subrogation against a judgment or recovery received by the Insured from a third party found liable for a wrongful act or omission that caused the Injury necessitating the Insured's payments. This recovery shall be up to the amount of Benefits paid for the Illness or Injury.

2. If the Insured intends to institute an action for damages against a third party, he shall give the company reasonable notice of his intention to institute the action.

3. The Company shall pay a proportionate share of the reasonable expenses of the third party action, including attorney's fees.

4. The Company's right of subrogation shall not be enforced until the Insured has been fully compensated for his Injuries.

C. **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).

IX. GENERAL POLICY INFORMATION

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

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

2. The number of Insured Dependents, 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 on either of the following dates:

1. On any premium due date provided the rate for such insurance has been in effect for at least twelve (12) months. Premium rates can be increased more frequently if failure to do so would violate the laws of the state of Montana or would cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its Policyholders or to the public. The Company will give written notice to the group Policyholder at least thirty-one (31) days prior to such premium due date.

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

The Company shall give at least 60 days advance notice of a change in rates.

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

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

C. **GRACE PERIOD:** A grace period of thirty-one (31) days will be allowed for payment of any premium due, unless the Policyholder gives written notice of discontinuance prior to the premium due date.

D. **TERMINATION OF POLICY:** If the Policyholder fails to pay any premium within the grace period, this Plan shall automatically terminate on the last day of such grace period. The Policyholder shall be liable to the Company for the payment of all premiums then due and unpaid, including a pro rata premium for the grace period. If the Policyholder gives written notice to the Company that this Plan is to be terminated before the end of the grace period, this Plan shall be terminated on the later of the date of receipt of such notice, or the date specified by the Policyholder. The Policyholder shall be liable to the Company for the payment of all premiums then due and unpaid. That amount shall include 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 Insured Employees, the beneficiary designated by each Employee, if any, the date when each Employee became Insured and the Effective Date of any change in coverage. This record shall also show any other information that may be required to administer the insurance. The Company shall furnish a copy of this record to the Policyholder, upon request. The Policyholder shall give the Company any information that is required for administering the insurance. This information shall include, but is not limited to, information for enrolling Employees, changes in coverage, and termination of insurance. Any records of the Employer and/or Policyholder that may have a bearing on this insurance shall be open for inspection by the Company at a reasonable time.

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

G. **FREE CHOICE OF PROVIDER:** The Employee shall have free choice of any legally qualified Physician or Practitioner and the Provider-patient relationship shall be maintained.

H. **CLAIM AND APPEAL PROCEDURES:**

A description of how the Plan processes claims and appeals follows. A claim is defined as any request for a Plan Benefit that is made by an Insured or by a representative of an Insured. Such request must comply with the procedures of the Plan for a claim being made. 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 and for request for further information. Each type of claim also has a specific time period for denial. Each type of claim also has a specific time period for review of appeals. Time periods begin at the time that a claim is filed. "Days" refers to calendar days, unless they are otherwise specified.

An insured individual has the right to contact the Montana Commissioner of Insurance and Securities for help at any time. They may be contacted in writing at 840 Helena Avenue, Helena, MT 59601. They may also be contacted by telephone at (800) 332-6148 or (406) 444-2040.

Pre-Service Claim

A pre-service claim is a request for Benefits or a request for payment for health services that requires pre-certification before Benefits will be received. Pre-certification is required for pre-service claims that involve an Inpatient facility confinement. The utilization review company that conducts Pre-certification is MedWatch. They may be contacted by telephone at (800) 432-8421. The Insured will receive a notification of the benefit determination for a pre-service claim within seven (7) business days after the receipt of the request. The plan may extend this time period for an additional seven (7) business days. Such extension will be for reasons that are beyond the control of the plan. The Insured will be notified in writing prior to the expiration of the initial seven (7) business day period of the circumstances that require the extension of time. The notice will include the date by which a decision will be rendered. If the extension is needed due to the failure of the Insured to submit information that is necessary to make a determination on the claim, the written notice will describe the required information that is necessary to complete the request. The Insured will be given at least forty-five (45) days to

respond to the notice. A notification of the benefit determination will be sent within seven (7) business days after the receipt of the additional information. If a request for a pre-service claim that fails to meet the filing procedures is received, notice will be sent to the Insured regarding the proper procedures that are to be followed for filing a request. This notice will be provided as soon as possible but no later than three (3) days after the date of the failure. The notice may be provided orally. The notice may also be provided in writing or in electronic form if it is requested by the Insured or the authorized representative of the Insured.

Pre-Service Urgent Care Claim

Pre-certification for pre-service claims that involve Urgent Care is **not** required, although it is recommended. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. If Pre-certification is performed for a pre-service claim that involves Urgent Care, the benefit determination will be made within forty-eight (48) hours. If a request for an Urgent Care pre-service claim that fails to meet the filing procedures is received or is incomplete, notice will be sent to the Insured regarding the proper procedures to be followed for filing a request. This notice will be provided as soon as possible but no later than twenty-four (24) hours after the receipt of the request. The Insured will be given at least forty-eight (48) hours to provide the necessary information. A benefit determination will be provided within twenty-four (24) hours after the necessary information is received. This notice may be provided orally. This notice may also be provided in writing or electronically. Notice will also be provided in written or electronic form within three (3) days following an oral notification.

Pre-Service Concurrent Urgent Care Claim

For concurrent review Urgent Care requests that involve a request by the Insured to extend the course of the treatment beyond the initial period of time or treatments, a determination will be made no later than twenty-four (24) hours after the date of the request. The determination will be made within this time period as long as the request was filed at least twenty-four (24) hours prior to the time when the approved period of time or the number of treatments expire. An ongoing course of treatment for which Pre-certification has been received may not be reduced or terminated unless a written notice is provided to the Insured. This notice must be provided well in advance to allow the Insured to appeal the determination and to obtain a decision prior to the reduction or termination.

Post-Service Claim

A post-service claim is any claim that involves the cost for medical care that has already been rendered to the Insured. Post-service claims will never be considered to be claims that involve Urgent Care.

The Insured will receive a notification of the benefit determination in the event of a post-service claim. The notification will be received within thirty (30) days after the receipt of the request. The plan may extend this time period for an additional fifteen (15) days for reasons that are beyond the control of the plan. The plan will notify the Insured in writing of the reasons that the extension of time is required and of the date by which a decision will be made. If the extension is necessary due to the failure of the Insured to submit the information that is necessary to make a determination on

the claim, the written notice will describe what is needed to complete the request. The Insured 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 rescission or a denial of, a reduction of, a termination of, or a failure to provide or to make payment for, in whole or in part, a Benefit. A denial of, a reduction of, a termination of or a failure to provide or to make payment that is based on a determination of whether an individual is eligible to participate in the plan is also an adverse benefit determination. In the event of an adverse benefit determination, the plan will provide a written or an electronic notification that sets forth the information that follows.

a) Information that is sufficient to identify the benefit request or the claim that is involved. This will include, if applicable, the date of service, the health care provider and the claim amount.
b) A statement that the diagnosis code and its corresponding meaning and the procedure code and its corresponding meaning are available upon request.
c) The specific rationale behind the adverse determination. This will include the denial code and its corresponding meaning. This will also include a description of the standard of the insurer, if any, that was used to deny the benefit request or claim.
d) A reference to the specific Plan provision on which the determination is based.
e) A description of any additional material or information that is necessary for the Insured to complete the benefit request. This includes an explanation of why the material or the information is necessary to complete the request.
f) A description of the appeal procedures of the Plan and any time limits that apply to those procedures.
g) A statement that any internal rule, guideline, protocol or other similar criteria that was relied on to make the adverse benefit determination will be provided to the Insured. This information will be provided upon request and free of charge.
h) A statement that an explanation of the scientific or the clinical judgement for the adverse benefit determination being made will be provided to the Insured. This statement will be provided if the adverse determination is based on a medical necessity or an experimental or an investigational provision of the Plan. This information will be provided upon request and free of charge.
i) A statement that explains that further assistance is available from the office of the commissioner and the right of the Insured to contact such office at any time for help. This statement will include the contact information for the commissioner.
j) A statement that explains the right of the Insured to file a suit in court pursuant to §502 of the Employee Retirement and Income Security Act ("ERISA"). Such suit can be filed after the internal and external appeal review procedures of the Company are completed.

If the adverse benefit determination is a rescission, the notice shall provide, in addition to the information above, the information that follows.

a) The alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact, will be clearly identified.
b) An explanation of why the act, practice, or omission was fraudulent or was an intentional misrepresentation of material fact.
c) The date when the advance notice period ends and the date to which the coverage is retroactively rescinded.
d) A notice that the Insured may immediately file an appeal with the Company to request a review of the rescission.
e) A description of the appeals procedures of the Company and any time limits that apply to those procedures.

Internal Appeals Process

The Plan provides two levels of internal appeal review. Both of these levels must be exhausted before an Insured can file a suit in court. In the event of an adverse benefit determination, the Insured has 180 days from the receipt of the notification in which to file a first level of appeal. Appeals that involve Urgent Care may be made orally; all other appeals must be made in writing. Notification of an appeal for a pre-service claim must also be given to the Company. Appeals should be filed to the appropriate entity as listed below.

For pre-service claims:

Name: MedWatch
Address: P.O. Box 952679
Lake Mary, FL 32795-2679
Phone: (800) 432-8421
Fax: (407) 333-8928

For post-service claims:

Name: Marilyn Gettings
Title: Claims Manager
Address: WMI Mutual Insurance Company
P.O. Box 572450
Salt Lake City, UT 84157
Phone: (801) 263-8000
Fax: (801) 263-1189

An Insured may submit comments, documents, records and other information that relates to the claim. Upon request, an Insured will be given access to, and copies of, all documents, records, and other information that are relevant to the claim and that were used in the initial benefit determination. This information will be provided free of charge.

If an Insured receives an adverse decision on the first level of appeal, he may submit the appeal for a second level of review. The appeal for a second level of review must be submitted within sixty (60) days of the receipt of the decision on the first level. Any additional information that applies must be submitted at the same time.

Each level of review may be performed either internally or independently, as described herein. In the case of a pre-service claim, each level of appeal will be responded to within fifteen (15) days after the receipt of the appeal, unless the appeal is for a pre-service Urgent Care claim. Appeals for pre-service Urgent Care claims will be responded to within seventy-two (72) hours. In the case of a post-service

claim, each level of appeal will be responded to within thirty (30) days after the receipt of the appeal. The time period within which a determination is required to be made will begin at the time that an appeal is received.

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

Reviews of all appeals of adverse benefit determinations, except those described in the paragraph that follows, will be conducted internally by a person or by a committee of persons. This person or committee of persons will not be the individual who made the initial adverse benefit determination. This person or committee of persons will also not be the subordinate of that individual.
An independent review will be conducted for an appeal of an adverse benefit determination that is based on a medical judgment. This includes a determination that a particular treatment, a drug or other item is experimental or is investigational. This also includes a determination that a particular treatment, a drug or other item is not Medically Necessary or is not appropriate. For this review, the plan will consult with an independent health care professional. This professional will not be affiliated with the Company. This professional will not be involved in the initial benefit determination. This professional will have the appropriate training and the expertise in the field of medicine that is involved in the medical judgment. This health care professional shall consider all comments, documents, records, and other information in regard to the request for review. This shall be without regard to whether the information was submitted or was considered in the initial adverse determination that was made. An Insured does not have the right to attend the review. The Insured is entitled to submit written comments, documents, records and other material that relate to the request for benefits for the reviewer to consider. The Insured is entitled to receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information that are relevant to the request for benefits. There will not be a fee charged to the Insured for an independent review.

Notice of Internal Appeal Review Decision

A written notice will be provided to the Insured upon the review decision and within the required timeframes. This notice will contain the information that follows.

a) Information that is sufficient to identify the benefit request or the claim that is involved. This will include, if applicable, the date of service, the health care provider and the claim amount.
b) A statement that the diagnosis code and its corresponding meaning and the procedure code and its corresponding meaning are available upon request.
c) If the review involved an independent review, the titles and the qualifying credentials of the health care professional that participated in the review. This

will include a statement from the health care professional of their understanding of the grievance of the Insured.

d) If the review involved an independent review, the decision of the health care professional that conducted the review. This will include the contract basis or the medical rationale on which the decision was based.
e) A reference to the evidence or the documentation that was used as the basis for the decision.

If the review decision upholds the adverse determination, the information that follows will also be included in the notice.

a) All of the specific reasons that uphold the adverse determination. This will include the denial code and its corresponding meaning. This will also include a description of the standard of the insurer, if any, that was used in the denial being reached.
b) A reference to the specific Plan provision on which the determination is based.
c) A statement that the Insured is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information that are relevant to the request for benefits.
d) A statement that any internal rule, guideline, protocol or other similar criteria that was relied on to make the adverse benefit determination will be provided to the Insured. This will be provided upon request and free of charge.
e) A statement that an explanation of the scientific or the clinical judgement for making the adverse benefit determination will be provided to the Insured. This will be provided upon request and free of charge. This applies if the adverse determination is based on a medical necessity or an experimental or an investigational provision of the Plan.
f) A description of the procedure of how to request a second level of appeal review, or how to request an external review, if either of them apply.
g) A statement that explains that further assistance is available from the office of the commissioner and the right of the Insured to contact such office at any time for help. This will include the contact information for the commissioner.
h) A statement that explains the right of the Insured to file a suit in court pursuant to §502 of the Employee Retirement and Income Security Act ("ERISA"). Such suit can be filed after the internal appeal review procedures of the Company are completed.

External Review

A third appeal level that is known as an external review level is also available. This level is available once the internal appeals process is exhausted. The plan may waive the requirement for exhaustion in writing. Exhaustion is also waived if the Plan fails to comply with any of the requirements of the internal appeals process. An insured individual has the right to contact the Montana Commissioner of Insurance and Securities for help at any time. They may be contacted in writing at 840 Helena Avenue, Helena, MT 59601. They may also be contacted by telephone at (800) 332-6148 or (406) 444-2040. The external review level can only be used for adverse benefit determinations that are based on medical necessity, appropriateness of care, health care setting, level of care, or effectiveness of care. This review level can also be used for adverse benefit determinations for services that are experimental or that

are investigational. When filing a request for an external review, the Insured must authorize the release of any medical records that may be required to make a decision on the external review.

There are two options for an external review: (a) a standard review; and (b) an expedited review. An expedited review may not be provided for reviews that involve post-service claims. The expedited review option is available if both of the conditions that follow are met.

(a) The adverse benefit determination involves a medical condition for which the standard external review timeframe would seriously jeopardize the life or the health of the Insured.
(b) The adverse benefit determination concerns an admission, the availability of care, a continued stay, or a health care service for which the Insured received emergency services, but has not been discharged from a facility. The adverse benefit determination may also involve a service or a treatment that is experimental or is investigational.

Standard External Review for Adverse Benefit Determinations involving Medical Necessity

An Insured must submit a request for a standard external review in writing. This must be submitted within four (4) months from the date of the final adverse benefit determination. Within five (5) business days of the request being received, the plan will conduct a preliminary review to determine if all of the following are met.

a) The Insured is or was a covered individual at the time that the service or the treatment was requested in the event of a pre-service claim. The Insured was a covered individual at that time that the service or the treatment was provided in the event of a post-service claim.
b) The service or treatment that is the subject of the adverse determination is a covered service under the Plan but it is not covered due to a determination that it does not meet the Plan's requirements for medical necessity, appropriateness of care, health care setting, level of care, or effectiveness of care.
c) The Insured has exhausted the internal appeals process.
d) The Insured has provided all of the information that is necessary to process the external review.

Within one (1) day after the completion of the preliminary review, the plan will notify the Insured if the request is eligible for an external review. If the request is not complete, the notice will describe the information that is necessary to complete the review. If the request is not eligible for an external review, a notice will be provided to the Insured that explains the reason it is not eligible. This notice will contain a statement that informs the Insured of the right to appeal to the commissioner.

Within one (1) business day of a request being determined to be eligible for an external review, the plan will randomly assign an independent review organization (IRO) to conduct the review. The IRO will be assigned from the list that is compiled and that is maintained by the commissioner. Within one (1) business day of the IRO

being assigned, the plan will notify the Insured that an external review has been started. The notice will also inform the Insured that he/she may submit any additional information to the IRO to be considered in the review. Such information must be submitted in writing within ten (10) business days after the receipt of the notice.

Within five (5) business days after the IRO is assigned, the plan shall provide to the IRO the medical records, documents and any information that were used to make the adverse benefit determination. Failure by the plan to provide such documents and information may not delay the conduct of the external review. The IRO may terminate the external review and make a decision to reverse the adverse benefit determination. The IRO will notify the Insured and the Plan within one (1) business day if it makes this decision.

If the IRO receives any information that is submitted by the Insured, it shall forward such information to the insurer within one (1) business day. The plan may then reconsider its benefit determination. If the plan reverses its determination, a notice will be provided to the Insured and to the IRO. This notice will be provided within one (1) business day after the decision is made. The IRO must then terminate its external review.

The IRO will consider the information and the documents that follow when it conducts the standard external review.

a) The medical records of the Insured.
b) The recommendation that was made by the attending professional.
c) Consulting reports from appropriate health care professionals, and any other documents that are submitted by the Insured or by the Plan.
d) The terms of coverage under the Plan of the Insured to ensure that the decision of the IRO is not contrary to the terms and conditions of the Plan.
e) The most appropriate practice guidelines. These must include practice guidelines and standards that are based on evidence and that are generally accepted. These must also include any other practice guidelines that are developed by the federal government or by national or professional medical societies, boards, and associations.
f) Any clinical review criteria that apply that are developed and that are used by the insurer or by its utilization review organization.
g) The opinion of the clinical peer of the IRO after the provisions of the subsections above are considered to the extent the documents or information are available.

The IRO shall provide written notice to the Insured and to the Plan of its decision to uphold or to reverse the adverse benefit determination. This notice shall be provided within forty-five (45) days after the receipt of the request for the standard external review. The written notice shall include the information that follows.

a) A general description of the reason for the request for the external review.
b) The date that the IRO received the assignment to conduct the external review.
c) The time period over which the external review was conducted.
d) The date of the decision of the IRO.
e) The principal reasons for the decision.

f) The rationale for the decision.
g) References to the evidence of documentation. This includes the standards based on evidence that were considered in the decision being made.

If the IRO reverses the adverse benefit determination of the plan, the plan will immediately approve the coverage that was the subject of the adverse determination.

Expedited External Review for Adverse Benefit Determinations involving Medical Necessity

A request for an expedited external review may be made by telephone or by other expeditious manner. The same rules that apply to a standard external review apply to an expedited external review. The timeframes for decisions and notifications for an expedited external review are shorter.

An Insured may request an expedited external review in either of the situations that follow.

a) If the Insured received an adverse benefit determination and: (1) the Insured has filed a request for an internal Urgent Care appeal review; and (2) the adverse determination involves a medical condition for which the timeframe for completion of an internal Urgent Care review would seriously jeopardize the life or the health of the Insured or would jeopardize the ability of the Insured to regain maximum function.
b) If the Insured received a final adverse benefit determination and: (1) the adverse determination involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or the health of the Insured or would jeopardize the ability of the Insured to regain maximum function; and (2) the adverse determination concerns an admission, availability of care, continued stay, or health care service for which the Insured received emergency services but has not been discharged from a facility.

Immediately upon receipt of a request for an expedited external review, the plan will determine if the request is eligible for such review. The plan will take into consideration the same requirements as those for a preliminary review for standard external reviews. After the preliminary review is completed, the plan will notify the Insured if the request is eligible for an external review. If the request is not complete, the notice will describe the information that is necessary to complete the review. If the request is not eligible for an external review, a notice will be provided to the Insured that explains the reason it is ineligible. This notice will contain a statement that informs the Insured of the right to appeal to the commissioner.

Immediately after a request is determined to be eligible for external review, the plan will randomly assign an independent review organization (IRO) to conduct the review. The IRO will be assigned from the list that is compiled and that is maintained by the commissioner. Upon it being assigned, the plan shall provide to the IRO the medical records, documents and any information that was used to make the adverse benefit determination. This information shall be provided electronically, by telephone, by fax or by any other expeditious manner.

The IRO will provide the Insured and the plan with notice of its decision. The notice will be provided as expeditiously as possible, but no more than seventy-two (72) hours after the request is received for an expedited external review. If the notice provided is not in writing, the IRO must provide written confirmation to the Insured and to the plan within forty-eight (48) hours after the decision is verbally conveyed. The written notice will contain the same information that is required for a standard external review. If the IRO reverses the adverse benefit determination of the plan, the plan will immediately approve the coverage that was the subject of the adverse determination.

Standard External Review for Adverse Benefit Determinations involving Experimental/Investigational Services or Treatment

An Insured must submit a request for a standard external review in writing. This must be submitted within four (4) months from the date of the final adverse benefit determination. Within five (5) business days of the request being received, the Plan will conduct a preliminary review to determine if all of the following are met.

a) The Insured is or was a covered individual at the time that the service or the treatment was requested, in the event of a pre-service claim. The Insured was a covered individual at the time that the service or the treatment was provided in the event of a post-service claim.
b) The service or the treatment that is the subject of the adverse determination is a covered service under the Plan but it is not covered due to a determination that it is experimental or it is investigational for a particular medical condition.
c) The service or the treatment is not explicitly listed as an excluded benefit under the Plan of the Insured.
d) The treating health care provider of the Insured has certified that one of the following applies: (i) standard health care services or treatments have not been effective in the condition of the Insured being improved; (ii) standard health care services or treatments are not medically appropriate for the Insured; or (iii) there is no available standard health care service or treatment that is covered by the insurer that is more beneficial than the recommended or the requested service or treatment.
e) The treating health care provider of the Insured has recommended a health care service or a treatment that the physician certifies, in writing, is likely to be more beneficial to the Insured, in the opinion of the physician, than any available standard health care service or treatment.
f) A written certification may also be made by a physician who is licensed, who is board-certified, or who is eligible to take the examination to become board-certified. This physician must also be qualified to practice in the area of medicine that is appropriate to treat the condition of the Insured. The certification must state that scientifically valid studies that use accepted protocols demonstrate that the requested service or the treatment is likely to be more beneficial to the Insured than any available standard health care service or treatment.
g) The Insured has exhausted the internal appeals process.

Within one (1) business day of a request being determined to be eligible for an external review, the plan will randomly assign an independent review organization (IRO) to conduct the review. The IRO will be assigned from the list that is compiled

and that is maintained by the commissioner. Within one (1) business day of the IRO being assigned, the plan will notify the Insured that an external review has been started. The notice will also inform the Insured that he/she may submit any additional information to the IRO to be considered in the review. Such information must be submitted in writing within ten (10) business days after the receipt of the notice.

Within one (1) business day after the assignment is received, the IRO shall select a clinical peer to conduct the external review. Multiple peers may be selected if it is medically appropriate under the circumstances. In selecting the clinical peers, the IRO shall select physicians or other health care providers who meet the criteria listed below.

a) They are experts in the treatment of the medical condition of the Insured.
b) They are knowledgeable about the health care service or treatment that was recommended through recent or current actual clinical experience treating patients with the same or similar medical conditions of the Insured.
c) They hold a professional license that is not restricted in a state of the United States. Physicians must also hold a current certification by a recognized American medical specialty board in one or more areas that are appropriate to the subject of the external review.
d) They have no history of disciplinary actions or sanctions. This includes participation restrictions or a loss of staff privileges that are either taken or are pending by any hospital, government agency, governmental unit, or any regulatory body. This applies if the disciplinary actions or sanctions raise a substantial question as to the physical, mental or professional competence or moral character of the clinical peer.

Within five (5) business days after the IRO being assigned, the plan shall provide to the IRO the medical records, documents and any information that was used to make the adverse benefit determination. Failure by the plan to provide such documents and information may not delay the conduct of the external review. The IRO may terminate the external review and make a decision to reverse the adverse benefit determination. The IRO will notify the Insured and the plan within one (1) business day if it makes this decision.

If the IRO receives any information that is submitted by the Insured, it shall forward such information to the insurer. This information must be forwarded within one (1) business day. The plan may then reconsider its benefit determination. If the plan reverses its determination, notice will be provided immediately to the Insured, to the IRO and to the commissioner after the decision is made. The IRO then must terminate its external review.

Each clinical peer will consider the information and the documents that follow, to the extent that the information is available and is appropriate when the standard external review is conducted.

a) The medical records of the Insured.
b) The recommendation of the attending physician or the health care professional.

c) Consulting reports from appropriate health care professionals, and any other documents that are submitted by the Insured, by the plan or by the treating physician or health care provider of the Insured.
d) The terms of coverage under the Plan of the Insured to ensure that the decision of the clinical peer is not contrary to the terms and conditions of the Plan.
e) Whether: (i) the recommended or the requested service or treatment has been approved by the Food and Drug Administration; (ii) the recommended or the requested service or treatment is typically covered by other insurers or payers, such as Medicare; or (iii) medical or scientific evidence or standards that are based on evidence demonstrate that the expected benefits of the recommended or the requested service or treatment are more likely than not to be more beneficial to the Insured than any available standard health care services or treatments and that the adverse risks of such service or treatment would not be substantially increased over those of the available standard health care services or treatments.

Within twenty (20) days after being selected, each clinical peer shall provide an opinion to the IRO on whether the recommended or the requested service or treatment should be covered. The opinion of each clinical peer must be in writing and must include the information that follows.

a) A description of the medical condition of the Insured.
b) A description of the indicators that are relevant to determine whether there is sufficient evidence to demonstrate that the recommended or the requested service or treatment is more likely than not to be more beneficial to the Insured than any available standard health care services or treatments. The description shall state that the adverse risks of the recommended or the requested service or treatment would not be substantially increased over those of available standard health care services or treatments.
c) A description and an analysis of any standard that is based on evidence.
d) Information on whether the rationale of the clinical peer for the opinion is based on the pertinent medical records of the Insured or the recommendation of the attending physician or the health care professional.

Within twenty (20) days after the opinion of each clinical peer is received, the IRO shall make a decision and provide written notice to the Insured, to the plan and to the commissioner. If a majority of the clinical peers respond that the recommended or the requested service or treatment should be covered, the IRO shall make a decision to reverse the adverse benefit determination. If a majority of the clinical peers respond that the recommended or the requested service or treatment should not be covered, the IRO shall make a decision to uphold the adverse benefit determination. If the clinical peers are evenly split as to whether the recommended or the requested service or treatment should be covered, the IRO shall obtain the opinion of an additional clinical peer to help the IRO make a decision. The selection of the additional clinical peer may not extend the time within which the IRO is required to make a decision.

The written notice from the IRO shall include the information that follows.

a) A general description of the reason for the request for the external review.
b) The written opinion of each clinical peer. This shall include the opinion of each clinical peer as to whether the recommended or the requested service or

treatment should be covered and the rationale for the recommendation of the reviewer.

c) The date that the IRO received the assignment to conduct the external review.
d) The time period over which the external review was conducted.
e) The date of the decision of the IRO.
f) The principal reasons for the decision.
g) The rationale for the decision.

If the IRO reverses the adverse benefit determination of the plan, the plan will immediately approve the coverage that was the subject of the review.

Expedited External Review for Adverse Benefit Determinations involving Experimental/Investigational Services or Treatment

A request for an expedited external review may be made orally if the treating health care provider of the Insured certifies in writing that the recommended or the requested service or treatment that is the subject of the request would be significantly less effective if it is not promptly initiated. The same rules that apply to a standard external review apply to an expedited external review. The timeframes for decisions and notifications for an expedited external review are shorter.

An Insured may request an expedited external review in either of the situations that follow.

a) If the Insured received an adverse benefit determination and: (1) the Insured has filed a request for an internal Urgent Care appeal review; and (2) the adverse determination involves a medical condition for which the timeframe for completion of an internal Urgent Care review would seriously jeopardize the life or the health of the Insured or would jeopardize the ability of the Insured to regain maximum function.
b) If the Insured received a final adverse benefit determination and: (1) the adverse determination involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or the health of the Insured or would jeopardize the ability of the Insured to regain maximum function; and (2) the adverse determination concerns an admission, availability of care, continued stay, or health care service for which the Insured received emergency services but has not been discharged from a facility.

Immediately upon receipt of a request for an expedited external review, the plan will determine if the request is eligible for such review. The plan will take into consideration the same requirements as those for a preliminary review for standard external reviews. After the preliminary review is completed, the plan will notify the Insured if the request is eligible for an external review. If the request is not complete, the notice will describe the information that is necessary to complete the review. If the request is not eligible for an external review, a notice will be provided to the Insured that explains the reason that it is not eligible. The notice will contain a statement that informs the Insured of the right to appeal to the commissioner.

Immediately after a request is determined to be eligible for an external review, the plan will randomly assign an independent review organization (IRO) to conduct the review. The IRO will be assigned from the list that is compiled and that is

maintained by the commissioner. Upon it being assigned, the plan shall provide to the IRO the medical records, documents and any information that was used in the adverse benefit determination being made. This information shall be provided electronically, by telephone, by fax or by any other expeditious manner.

Within one (1) business day after the assignment is received, the IRO shall select a clinical peer to conduct the external review. Multiple peers may be selected if it is medically appropriate under the circumstances. Within five (5) days after being selected, each clinical peer shall provide an opinion to the IRO on whether the recommended or the requested service or treatment should be covered. The opinion may be provided either orally or in writing. If the notice provided is not in writing, the clinical peer must provide written confirmation to the IRO within forty-eight (48) hours after the decision is verbally conveyed. Within forty-eight (48) hours after the opinion of each clinical peer is received, the IRO shall make a decision and provide an oral or a written notice to the Insured, to the plan and to the commissioner. If the notice provided is not in writing, the clinical peer must provide a written confirmation to the IRO within forty-eight (48) hours after the decision is verbally conveyed. If a majority of the clinical peers respond that the recommended or the requested service or treatment should be covered, the IRO shall make a decision to reverse the adverse benefit determination. If a majority of the clinical peers respond that the recommended or the requested service or treatment should not be covered, the IRO shall make a decision to uphold the adverse benefit determination. If the clinical peers are evenly split as to whether the recommended or the requested service or treatment should be covered, the IRO shall obtain the opinion of an additional clinical peer to help the IRO make a decision. The selection of the additional clinical peer may not extend the time within which the IRO is required to make a decision.

The written notice will contain the same information that is required for a standard external review. If the IRO reverses the adverse benefit determination of the plan, the plan will immediately approve the coverage that was the subject of the review.

Binding Nature of the External Review Decision

An external review decision is binding on the insurer and the Insured except to the extent that the Insured has other remedies that are available under federal law or state law that may apply. An Insured may not file a subsequent request for an external review that involves the same adverse benefit determination for which the Insured already received an external review decision.

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

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

K. **NON-ASSESSABLE PLAN:** This Plan is non-assessable. If for any reason the Company is unable to maintain required reserves or pay justified claims for Benefits, Benefits may be reduced in accordance with an equitable plan approved by law.

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 Dependents shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Employee or his Dependent 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 state of Montana or immediately if such change is necessary in order to conform it to changes in the HSA and HDHP laws. The Plan may be amended by written agreement between the Policyholder and the Company without the consent of the Insured Employees or their beneficiaries. The Plan may also be amended on the Plan's renewal date upon sixty (60) days written notice from the Company to the Policyholder. If an Insured is confined in a Hospital or Extended Care Facility on the effective date of the amendment, Benefits shall not be affected until the date of discharge. No change in the Plan shall be valid until approved by a duly authorized officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change any Plan or waive any provision thereof.

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. The notice must have sufficient information to be able to identify the Insured Employee or Insured Dependent. Notice given to any authorized agent 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 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.

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

S. **OVERPAYMENTS:** If for any reason the Company pays any amounts to or on behalf of the Insured:

1. For services not covered under this Plan;
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 Insured Employee is responsible to reimburse the Company for all and any such amounts. The Company may also recover overpayments to or on behalf of an Insured from future claim payments due for services incurred by the Insured or any Insured Dependent if the health care provider or Insured has authorized the Company, in writing, to recover an overpayment by offsetting a future claim payment.

The following time limits apply for requesting overpayments:

1) Except as provided below, the Company has twelve (12) months following payment of a claim to perform any review or audit for reconsidering the validity

of a claim and to request reimbursement for payment of an invalid claim or overpayment of a claim.

2) Regardless of the period allowed by the Company for submission of claims for payment, the Company may perform a review or audit to reconsider the validity of a claim and may request reimbursement for an invalid or overpaid claim within twelve (12) months from the date upon which the Company received notice of a determination, adjustment, or agreement regarding the amount payable with respect to a claim by: a) Medicare; b) a workers' compensation insurer; c) another health insurance issuer or group health plan; d) a liable or potentially liable third party; or e) a foreign health insurer under an agreement among plans operating in different states when the agreement provides for payment by the Montana health insurance issuer as host plan to Montana providers for services provided to an individual under a plan issued outside of the state of Montana.
3) If the Company pays a claim in which the Company 1) suspects the health care provider or the Insured of insurance fraud related to the claim; and 2) has reported the fraud related to the claim to the insurance commissioner, the time limitation on the Company as described in subsection 1 above does not commence running until the date that the commissioner determines that insufficient evidence of fraud exists.
4) The time limitation on the Company as described in subsection 1 above does not commence running until the Company has actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, if the Company has paid a claim incorrectly because of an error, misstatement, misrepresentation, omission, or concealment, other than insurance fraud, by the health care provider or other person. Regardless of the date upon which the Company obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, the Company is not permitted to request reimbursement or to offset another claim payment for reimbursement of the claim more than twenty-four (24) months after payment of the claim.

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, furnishing proof of loss, or bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Policy is delivered, such limitation shall be extended to agree with the minimum period permitted by such law.

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

X. **CONFORMITY WITH MONTANA STATUTES:** The provisions of this Policy conform to the minimum requirements of Montana law. These provisions take control over any conflicting statutes of any state in which the insured resides on or after the Effective Date of this Policy.

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

Z. **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.

AA. **QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")**: A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order proceeding. A QMCSO requires that health plan coverage be provided to a child of the Employee. A copy of the Company's QMSCO procedures may be obtained free of charge, upon request.

X. PRIVACY POLICY

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

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

- **Disclosure of Information.** We may disclose your personal information to agents, health care providers, or service providers that perform business functions on our behalf. Examples of these types of functions are claims processing and utilization management. We obtain assurances from our service providers that they will also protect the privacy of your information. Personal information regarding a spouse or

dependent children will also be disclosed to the insured employee (or the insured former employee) in the form of an explanation of benefits when a claim is processed. We will not disclose your PHI outside of our normal business functions unless we first obtain 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.

WMI MUTUAL INSURANCE COMPANY

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