UTAH GROUP HEALTH INSURANCE CERTIFICATE BOOKLET

WMI Mutual Insurance Company

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

"Actively at Work" and **"Active Work"** means being in attendance in person at the usual customary place or places of business acting in the performance of the duties of the Employee's occupation on a full time basis devoting full efforts and energies thereto, except that an Employee shall be deemed Actively at Work on each day of a regular paid vacation, or on any day in which he/she is absent from work due to a health factor, for a period not to exceed twelve (12) weeks, provided he/she was Actively at Work on the last preceding regular work day. In the case of a new enrollee, eligibility will not be denied if the Employee is absent from work due to a health factor, however, work must begin before coverage will become effective.

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

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

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

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

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

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

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

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

"Company" means the WMI Mutual Insurance Company.

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

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

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

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

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

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

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

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

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

"Date Incurred" means the date services were provided.

"Deductible" means the amount of Eligible Charges paid 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) Child(ren), under age twenty-six (26); and

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

intervals during the two (2) years following the Child's attainment of the limiting age subsequent proof of his incapacity. After the two (2) year period, subsequent proof may not be required more than once each year.

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

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

(a) It is intended only for the patient's use and benefit in the care and treatment of an Illness or Injury.

(b) It is durable and usable over an extended period of time.

(c) It is primarily and customarily used for a medical purpose.

(d) It is prescribed by a Physician or Practitioner.

Durable Medical Equipment includes, but is not limited to, all types of wheelchairs, crutches, braces, hospital beds, CPAP machines, insulin pumps, pain management pumps, infusion-type pumps, and pacemakers. Durable Medical Equipment does not include air conditioners, swimming pools, hot tubs, exercise equipment, or similar equipment.

"Effective Date" as pertains to the Employer's Plan, the term, "Effective Date" shall mean the date the Employer's Plan becomes in force. As pertains to the Employee or Dependent, the term "Effective Date" shall mean the date the Employee or Dependent becomes insured.

"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 or 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 thirty (30) hours or more per week and who receives compensation for his services from the Employer. An Employee of the subsidiaries and affiliates, if any, of the Employer named on the face of this Plan, shall be deemed an Employee of the Employer and service with any such subsidiaries and affiliates shall be deemed service with the Employer, if in compliance with hours worked. For the purpose of this definition, an owner, sole proprietor, partner, officer or director shall be considered an "Employee" provided that he or she is Actively at Work as set forth herein.

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

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

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

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

"Family Out-of-Pocket" means two (2) times the individual Out-of-Pocket. No individual family member may contribute more than one-half of the Family Out-of-Pocket maximum and each family member must satisfy an individual Deductible amount (unless the Family Deductible has been satisfied) even if the Family Out-of-Pocket maximum amount has been satisfied. Only eligible Deductible and co-insurance amounts 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.

"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 that is licensed and operates within the scope of such license.

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

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

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

"Injury" means Accidental Bodily Injury sustained by the Insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, which occurs while insurance coverage is in force, for which the Insured is not entitled to receive any Benefits under any worker's compensation or occupational disease law.

"Inpatient" means treatment that is provided while admitted to, and confined in, a Hospital setting for at least twenty-four (24) hours, and includes services such as lodging and meals.

"Insured" means the Insured Employee or Insured Dependent(s).

"Insured Dependent" means the Dependent of an Insured Employee for whom premium was paid.

"Insured Employee" means an Employee who is eligible for insurance as defined in this Plan and for whom premium was paid.

"Medicaid" means the programs providing Hospital and medical Benefits under Title XIX,"Grants to States for Medical Assistance Programs", of the Federal Social Security Act as now in effect or amended hereafter.

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

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

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

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

(d) Covered under the Policy.

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

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

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

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

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

"Occupational Therapy" means the use of any occupation or creative activity for remedial purposes to retrain the patient in work activities (school, home management, and employment). Occupational Therapy is directed toward the coordination of finer, more delicate movements than Rehabilitation/Physical Therapy, such as coordination of fingers, to the sick or injured person's highest attainable skills.

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

"Open Enrollment" means the period between November 1 and December 31 during which an Employee or Dependent who previously waived coverage may enroll in the insurance Plan. An individual who enrolls in the Plan during the Open Enrollment period will become effective on January 1. An Employee or Dependent who waives insurance coverage during the Open Enrollment period must wait until the next Open Enrollment period to enroll in the insurance Plan.

"Out-of-Pocket" means the maximum dollar amount per year of Eligible Charges payable by an Insured to Providers. No individual family member may contribute more than one-half of the Family Out-of-Pocket maximum. Only eligible Deductible and co-insurance amounts that are paid by the Insured during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Deductible amounts must be satisfied for each individual family member (unless the Family Deductible has been satisfied) even if the Family Out-of-Pocket maximum amount has been satisfied. The Out-of-Pocket amounts are specified in the Schedule of Benefits section of this booklet.

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

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

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

"Policyholder" means the Employer named on the Certificate.

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

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

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

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

"Prescription Drug" means a drug or medicine which can only be obtained by a Prescription Order and bears the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription" or other similar type of wording, or which is restricted to prescription dispensing by state law.

The term Prescription Drug **does not** include insulin, diabetic testing equipment, and supplies for insulin, which are covered elsewhere in the Policy.

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

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

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

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

(a) Resident beds or residential units;

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

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

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

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

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

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

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

"Scientific Evidence" means:

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

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

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

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

"Special Enrollment" means an enrollment period, other than the Employer's initial enrollment period or annual Open Enrollment period, when Employees and Dependents are eligible to enroll in the Plan pursuant to the enrollment provisions of the Plan.

"Spouse" means the person who is legally married to the Insured person.

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

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

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

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

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

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

II. ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE:

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

A. **ELIGIBILITY DATE FOR EMPLOYEES OF NEWLY ENROLLED EMPLOYER GROUPS:** Employees who worked an average of thirty (30) hours or more per week during the preceding month are eligible to participate in the Plan on the Effective Date of the

Employer's Plan. Employees must enroll in the Plan prior to the Employer's Effective Date. In order to enroll, Employees must submit a properly completed enrollment card to the Company. Any eligible Employee who does not enroll prior to the Effective Date of the Employer's Plan cannot enroll in the Plan until the next Open Enrollment period.

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

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

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

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

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

C. **ELIGIBILITY DATE FOR DEPENDENTS:** Eligible Dependents may enroll in the Plan, by submitting a properly completed enrollment card to the Company, at the time of enrollment of the eligible Employee. Eligible Dependents who enroll at the same time as the Employee are eligible to participate in this Plan on the same day as the Employee. An eligible Dependent who does not enroll at the same time as the eligible Employee 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 involuntarily lost the other coverage. If the other coverage is provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Employee may only enroll after the COBRA coverage has been involuntarily exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, coverage through this Plan must be requested within sixty (60) days after the termination.

2. Employees who marry or acquire a Child through birth, adoption, or placement for the purpose of adoption. The Employee must enroll within the first thirty-one (31) days of eligibility.

3. Eligible Dependents of Employees Insured under the Plan, when the eligible Dependent declined participation in the Plan when the Dependent was first eligible because other health insurance was maintained and the Dependent has since involuntarily lost the other coverage. If the other coverage is COBRA coverage, the Dependent may only enroll after the COBRA coverage has been involuntarily exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, coverage through this Plan must be requested within sixty (60) days after the termination.

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

   a. A spouse may enroll in the Plan at the time of marriage or when a Child is born, adopted or placed for the purpose of adoption. Enrollment must be within thirty-one (31) days of eligibility.

   b. A newborn Child is automatically covered from the moment of birth for a period of thirty-one (31) days and an adopted Child is automatically covered from the date the Child is placed for the purpose of adoption for a period of thirty-one (31) days. If the payment of a specific premium is required to provide coverage for a newborn or adopted Child, the Insured Employee must enroll the eligible Child within thirty-one (31) days from the date of birth or placement for adoption and must pay all applicable premium within the thirty-one (31) day period, in order for the coverage of a newborn or adopted Child to extend beyond the thirty-one (31) day period.

5. An Insured who is required by a court or administrative order to provide health coverage to a Child, who is otherwise eligible for coverage, shall be permitted to enroll the Child outside of any Open Enrollment period. If the Insured is enrolled but fails to make application to enroll the Child, the Company shall enroll the Child upon application by the Child's other parent, by the state agency administering the Medicaid program, or by the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program.

6. 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. **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.

F. **MAINTENANCE OF EMPLOYEE ELIGIBILITY:** Active Employees are eligible to participate in the Plan as long as they are Actively at Work in the regular business of an

Employer. Active Employees must work an average of at least thirty (30) or more hours per week while receiving compensation for such service from the Employer.

G. **MAINTENANCE OF GROUP ELIGIBILITY:** The Company requires that 100% of all of the Employees participate if there are three (3) or fewer Employees that are eligible for the insurance. The Company requires that 75% all of the Employees participate if there are four (4) or more Employees that are eligible for the insurance. The Company may terminate this Plan for failure to meet participation requirements on any renewal date by giving written notice to the Policyholder at least thirty-one (31) days in advance.

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 received timely by the Company, coverage will automatically be terminated as of the end of the last day for which a premium has been paid. Reinstatement of coverage for a terminated insurance group may be allowed provided that all requirements of the Company have been met. All premiums are due on the first day of each calendar month and shall be considered delinquent on or before the 10th day of the month that such premiums are due.

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

B. **TERMINATION OF DEPENDENT COVERAGE:** The Dependent's coverage shall automatically terminate on the earliest of the following dates:

1. The last day of the month in which the covered Dependent ceases to be eligible as a "Dependent" as defined the Definitions section of the Policy.

2. The date the Employee's coverage under the Plan terminates.

3. The date of expiration of the period for which the last premium is made on account of an Employee's Dependent Coverage.

4. A Dependent's insurance under this Plan may be immediately terminated if he has performed an act or practice that constitutes fraud. A Dependent's insurance may also be terminated if he has made an intentional misrepresentation of material fact under the terms of the coverage. The Company will provide a 30-day advance notice to the Insured

prior to such rescission or termination. In addition, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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

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

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

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

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

1. **Inpatient Hospital Services**. Eligible services include Semi-private Room Accommodations or Intensive Care room accommodations. Eligible services also include necessary miscellaneous supplies such as, but not limited to, laboratory procedures; operating room, delivery room, recovery room; anesthetic supplies; surgical supplies; oxygen and use of equipment for its administration; x-ray; intravenous injections and setup; pharmacy services; special diets; respiratory therapy, chemotherapy, radiation therapy, and dialysis. Human pasteurized milk is a covered Benefit for newborns in Intensive Care whose mother's milk supply is inadequate, and in cases of extreme immaturity. Treatment may be provided by a skilled nursing facility, as an alternative to

Inpatient Hospital services. Eligible skilled nursing facility costs include professional services, pharmacy services, and prescriptions filled in the skilled nursing facility pharmacy. The plan limits skilled nursing facility services to thirty (30) days per Calendar Year.

2. **Inpatient Mental Illness Care**. Eligible 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.

3. **Inpatient Alcohol/Substance Abuse Treatment**. Eligible treatment must be rendered in an Alcohol/Substance Abuse Dependency Treatment Center as defined in the Policy and must also meet all other criteria for eligibility subject to all other terms and provisions of the Policy in order for Benefits to be provided.

4. **Inpatient Extended Care Facility/Rehabilitation Care Facility**. The eligible amount for the daily room charge incurred at an Extended Care or Rehabilitation Care Facility is limited to the most common daily Semi-private room charge by the Extended Care Facility/Rehabilitation Care Facility. All other Covered Expenses will be paid in accordance with the policy guidelines. The Benefit is limited to a maximum of thirty (30) days in any one Calendar Year. Custodial Care is not considered to be Extended Care or Rehabilitation Care and is ineligible for Benefits.

B. **OUTPATIENT HOSPITAL AND AMBULATORY PATIENT SERVICES:** Outpatient services, supplies and treatment that are provided by a Hospital or in an Ambulatory Service Facility will be paid as set forth in the Schedule of Benefits.

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

D. **OUTPATIENT ALCOHOL/SUBSTANCE ABUSE TREATMENT:** Eligible outpatient treatment must be rendered by a Provider or Practitioner or in an Alcohol/Substance Abuse Dependency Treatment Center as those terms are defined in the Policy in order to be eligible for Benefits. Treatment must also meet all other criteria for eligibility subject to all other terms and provisions of the Policy in order for Benefits to be provided.

E. **GENERAL SURGICAL SERVICES:**

1. The Plan covers surgical procedures performed by the primary surgeon.

2. 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.

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

4. Multiple or Bilateral Surgical Procedures. When multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same time and through the same incision, the available Benefits shall be the value of the major procedure plus 50% of the value of the lesser procedure. When multiple procedures are performed through separate incisions or in separate sites, the available Benefit shall be the value of the major procedure plus 75% of the value of the 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.

F. **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.

G. **PHYSICIAN SERVICES:**

1. **Office Visits:** Office Visits provided by a Physician, specialist, or other Practitioner, and associated supplies and services, including therapeutic injections, that are Medically Necessary to treat and Illness or Injury are covered.

2. **Physician Consultations:**

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

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

(c) There is a limit of one Physician or Provider Visit allowed for each day.

(d) Concurrent Physicians Services:

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

(ii) A patient who is admitted to the Hospital for a medical condition and is then transferred to the Hospital's surgical service for the same condition but under the care of another Physician, is entitled to Hospital Physician Benefits only from the date of admission to the date of transfer to the surgical service.

Thereafter, the patient is only entitled to the Benefit for surgical services unless the surgery performed is diagnostic, a myelogram, or endoscopic procedure.

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

H. **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 (6) 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. Hospice care is limited to a maximum of six (6) months in a three-year period.

I. **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:

   (i) Heart; (ii) arteries; (iii) veins; (iv) intra-ocular lenses; (v) corneas; (vi) kidneys; (vii) skin; (viii) tissues; (ix) all joints of the body; (x) heart/lung combined; (xi) liver; (xii) lung (single or double); (xiii) pancreas; and (xiv) 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 this provision, 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 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. Diagnostic, medical and surgical expenses for a compatible live or cadaveric donor that are directly related to the transplant are eligible for Benefits 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.

3. The Usual and Customary amount for Implantable Hardware, as defined in the Policy, shall be limited to the invoice cost plus 50%. This maximum allowable amount applies to services rendered at PPO and non-PPO facilities. An invoice showing the actual cost of the Implantable Hardware must be submitted to the Company.

4. Only organs and body parts specifically listed in this section are eligible for transplant or implant Benefits.

J. **DIAGNOSTIC LABORATORY TESTS, X-RAY EXAMINATIONS AND IMAGING:** The following services are covered when authorized by a Physician and when required as the result of Injury or Illness.

1. Laboratory services, supplies, and tests.

2. Radiology services, including x-ray, MRI, CT scan, PET scan, and ultrasound imaging.

K. **MATERNITY SERVICES:**

1. Maternity Benefits are paid on a female Employee or a 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 or newborn Child to less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section. It is unnecessary for a Provider to obtain pre-authorization from the Company for a length of stay within these time limitations. Maternity coverage does not include a Dependent Child's spouse. Although not required, it is recommended that the expectant mother call the Pre-certification company during the first trimester so that a review for a possible high risk pregnancy can be performed.

2. The initial care of a newborn that is provided by a Physician at birth, standby care provided by a pediatrician at a cesarean section, and nursery care of newborn infants is subject to separate cost sharing under the newborn Child's own coverage. This includes, but is not limited to, a separate deductible.

3. Prenatal and postnatal care and services, including screening, are covered. Prenatal ultrasounds are limited to two (2) routine ultrasounds per pregnancy. Additional ultrasounds are allowed if they are deemed Medically Necessary by the Physician due to a condition of risk to the mother or child.

4. Benefits for intrauterine genetic evaluations (amniocentesis or chorionic villi sampling) are eligible for high-risk pregnancy.

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

L. **REHABILITATIVE AND HABILITATIVE SERVICES:** Benefits include the following:

1. Physical therapy, speech therapy, Occupational Therapy and habilitative services are covered when Medically Necessary and when rendered by a Provider operating within the scope of their license. Treatment is limited to twenty (20) outpatient visits per Calendar Year, on a combined basis, when rendered for rehabilitative/habilitative purposes.

2. Cardiac rehabilitation therapy, such as, but not limited to, use of common exercise equipment while under a Physician's care. Phase 2 therapy is eligible following a heart attack, cardiac surgery or severe angina, and is limited to a maximum of five (5) visits per Calendar Year. The therapy must take place in a formal rehabilitation program at an accredited facility, and must be prescribed by a Physician. Therapy must be rendered within ninety (90) days following cardiac Illness or surgery in order to be eligible. Therapy for phases 3 and 4 is ineligible for Benefits.

3. Therapy for pulmonary rehabilitation is covered while under a Physician's care. Phase 2 therapy resulting from chronic pulmonary disease or surgery is eligible, and is limited to a maximum of five (5) visits per Calendar Year. The therapy must take place in a formal rehabilitation program at an accredited facility, and must be prescribed by a Physician. Therapy must be provided within ninety (90) days following the diagnosis of pulmonary illness or surgery in order to be eligible. Therapy for phase 3 is ineligible for Benefits.

4. Braces, splints, prostheses, orthopedic appliances, and supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts are covered. Knee braces are limited to one (1) per knee in a three-year period. Breast prosthetics are limited to one (1) per affected breast in a two-year period. Artificial eye prosthetics are limited to one (1) in a five-year period. Prosthetics for artificial limbs are limited to the initial prosthetic device, unless the initial device is no longer serviceable and it cannot be made serviceable. Foot orthotics, orthopedic shoes and shoe inserts are ineligible for coverage.

5. 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. Power wheelchairs are limited to one (1) in a five-year period.

M. **PREVENTIVE AND WELLNESS SERVICES INCLUDING CHRONIC DISEASE MANAGEMENT:** The following services are covered.

1. Screening and tests with a rating of A or B in the U.S. Preventive Services Task Force for prevention and chronic care. Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and tobacco cessation products, are covered when obtained with a Prescription Order according to the guidelines set forth in the U.S. Preventive Services Task Force.

2. Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. This Benefit includes influenza immunizations.

3. Services, tests and screenings contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians for infants, children, and adolescents.

4. Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness guidelines. Benefits include, but are not limited to, all contraceptive methods approved by the Food and Drug Administration ("FDA"), including insertion or extraction of FDA-approved contraceptive devices, and tubal ligation.

5. Other wellness services not set forth in the above guidelines, including well baby/child visits, routine physical examinations and check-ups.

6. Prostate cancer screening is covered when ordered by the Insured's Physician or Practitioner.

7. A colonoscopy is covered, subject to the following guidelines in accordance with the American Cancer Society:

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

   (b) 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.

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

9. Chronic disease management services.

N. **PEDIATRIC VISION SERVICES:** The following services are covered for Children from age five (5) through the age of eighteen (18).

1. One routine vision screening and eye exam each Calendar Year, including dilation if professionally indicated, and with refraction. **Note:** One routine vision screening and

eye exam each Calendar Year is allowed for Children between age three (3) and age five (5) under the preventive and wellness services section of the Plan.

2. One pair of prescription lenses each Calendar Year. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular. Two pairs of glasses may not be ordered in lieu of bifocals.

3. One pair of frames each Calendar Year.

4. Contact lenses are covered once each Calendar Year in lieu of lenses and frames.

O. **PEDIATRIC DENTAL SERVICES:** The following services are covered for Children through the age of eighteen (18) (other age limits apply as specified below). Benefits are subject to all other Policy provisions and are eligible only when determined to be necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols. There are no Benefits for oral implants.

a. Periodic oral examinations are limited to two (2) exams per Calendar Year, from age three (3) through eighteen (18). Prophylaxis is limited to twice per Calendar Year.

b. Complete mouth x-rays (posterior bitewing films and 14 periapical films plus bitewings) are allowed once during any three-year period, for Children from age three (3) through eighteen (18), in lieu of a panorex x-ray. A panorex x-ray is allowed once during any during any three-year period in lieu of complete mouth x-rays. Full series bitewing x-rays (4) are allowed twice per Calendar Year.

c. Vertical bitewing x-rays are allowed up to eight (8) films.

d. Topical fluoride.

e. Sealants are allowed once during any five-year period on permanent molars, for Children through seventeen (17) years of age. Permanent molars include teeth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31 and 32. Permanent molars with occlusal restoration are ineligible.

P. **GENERAL COVERED SERVICES AND SUPPLIES:** Except as otherwise limited by this Policy, the following services and supplies are covered.

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

2. Urgent care visits to treat an Injury or Illness, including Provider services, facility costs and supplies are covered.

3. Oxygen and equipment for its administration are covered.

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

5. Back and spine manipulations and modalities are covered.

6. Diagnostic colonoscopies are covered. Screening colonoscopies are covered elsewhere under the preventive and wellness services section of the Plan.

7. Home Health Care is covered for an Insured who is homebound and who would otherwise require hospitalization. Benefits are limited to thirty (30) Visits in any one Calendar Year. 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) Physical therapy;

   (c) Occupational therapy;

   (d) Speech therapy;

   (e) Hospice service;

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

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

   Physical therapy, Occupational therapy and speech therapy are limited to the outpatient visit limit as set forth elsewhere in the rehabilitative/habilitative section of the Plan.

8. Ambulance is covered if the services are reasonably necessary for an Accident or Illness. The services must be provided to the nearest Hospital providing the level of care needed. Benefits for air ambulance are payable only for a life-threatening Emergency when an Insured can not be safely transported by ground ambulance.

9. The first lens purchased in conjunction with cataract surgery is covered.

10. 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.

11. Circumcisions are covered if performed within thirty (30) days of birth.

12. The Plan covers treatment for inborn errors of amino acid or urea cycle metabolism including medical services and dietary products. The dietary products must be prescribed by a Physician and must be the major source of nutrition for the Insured.

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

14. The Plan covers reconstructive breast surgery resulting from a mastectomy. The Plan covers all stages of one reconstructive breast surgery on the nondiseased breast to

establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed.

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

For purposes of this section, the term "reconstructive surgery" shall mean a surgical procedure performed following a mastectomy on one breast or both breasts to establish symmetry between the two breasts. The term includes but is not limited to, augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Benefits for reconstructive breast surgery include, but are not limited to, two prosthetic devices incident to a covered mastectomy, mastectomy bras, physical complications of a mastectomy, including lymphedemas, and benefits for outpatient chemotherapy following surgical procedures.

15. Drugs and medicines that require a Prescription Order and that are prescribed for the condition(s) for which they are approved for use by the Food and Drug Administration ("FDA") are covered, unless otherwise excluded as set forth elsewhere in this Policy. Eligible Generic, Brand and specialty Prescription Drugs are covered. Generic Prescription Drugs must be used whenever a Generic equivalent is available. If a Brand name drug is purchased instead of a Generic equivalent, the Insured is responsible for the price difference. Prescribed, anticancer medications that are administered orally and that are used to kill or slow the growth of cancerous cells are paid as major medical expenses and are not paid as Prescription Drug Benefits. This Benefit includes medication prescribed as part of a clinical trial, which is not the subject of the trial. This Benefit also includes 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), even if they are administered by a Provider. In accordance with the Policy provisions for determining medical necessity, some Prescription Drugs are subject to maximum dispensing limitations at either a retail pharmacy or through the mail order program. These limits are based on clinically approved prescribing guidelines and are regularly reviewed to ensure medical necessity and appropriateness of care. Prescription drugs that exceed the manufacturer's recommended dosage or the dosage established by the FDA are not covered. The Company is entitled to any and all available rebates that are paid by Prescription Drug manufacturers.

    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.

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

17. The Usual and Customary amount for Implantable Hardware, as defined in the Policy, shall be limited to the invoice cost plus 50%. This maximum allowable amount applies to services rendered at PPO and non-PPO facilities. An invoice showing the actual cost of the Implantable Hardware must be submitted to the Company.

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

19. Benefits for the medically necessary treatment and management of diabetes, as follows:

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

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

21. Nutritional analysis or counseling in conjunction with anorexia, bulimia, or as allowed under the preventive and wellness services Benefit, when deemed medically necessary and prescribed by an attending physician.

22. Maxillary/mandibular bone or calcitite augmentation surgery is eligible for Benefits if the Insured is edentulous (absence of all teeth) and the general health of the Insured is at risk because of malnutrition or possible bone fracture.

23. Emergency room services, supplies and treatment are covered. 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.

24. Emergency and non-Emergency care when traveling outside of the United States is covered.

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

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

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 date of the Insured’s coverage.

2. Expenses covered by any workers' compensation law; Employers' liability law (or legislation of similar purpose); occupational disease law; or for Injury arising out of, or in the course of, employment for compensation, wages or profit. This exclusion does not apply to an Owner who has elected the optional 24-hour coverage and has paid the applicable premium.

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

4. Expenses covered under automobile or vehicle medical payment provisions or under an automobile or vehicle No-Fault Insurance Act, or which would have been covered under No-

Fault insurance coverage when the party is legally responsible for having No-Fault coverage in place. This exclusion applies whether or not the No-Fault coverage is actually in effect.

5. Expenses for any loss to which the contributing cause was the Insured's or Dependent's 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, including but not limited to, declared or undeclared war; or acts of aggression committed by a person entitled to Benefits.

7. Examinations, reports, or appearances that are in connection with legal proceedings. This exclusion also applies to services, supplies, or accommodations that are provided pursuant to a court order, whether or not Illness or Injury is involved.

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

9. Expenses in connection with transplant types that are not specifically set forth elsewhere in the Policy as being eligible for Benefits are not covered. 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. This exclusion also does not apply when expenses are incurred for reconstructive surgery after a mastectomy, or for repair of a congenital anomaly.

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

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

13. Expenses 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, unless elsewhere specified in the Policy.

15. Expenses for care or treatment of Mental Illness unless and until there exists a confirmed diagnosis of the Mental Illness. The diagnosis of Mental Illness must be made pursuant to a personal examination of the patient by a Provider that is licensed to make such diagnosis.

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

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

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

19. Care or treatment of psychosexual identity disorder; transsexualism; sexual transformation; or psychosexual dysfunction.

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

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); or 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 are, as determined by the Company, for the primary purpose of controlling or changing the environment of the Insured.

26. Expenses in connection with Inpatient charges for a Residential Care Facility/Institution are not covered. Expenses that would otherwise be eligible for Benefits if not provided in this type of facility will be considered for Benefits on an outpatient basis, subject to all other Policy provisions, if billed separately from the facility charges.

27. Expenses for facility charges at an Ambulatory Service Facility or a Hospital when the facility is not approved by the Joint Commission on Accreditation of Hospitals ("JCAH".)

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

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

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

31. Expenses for: (1) Injuries resulting directly or indirectly, in whole or in part, from the Insured operating any motorized vehicle, including watercraft, while exceeding the legal limit of intoxication; or (2) Injuries resulting directly or indirectly, in whole or in part, from the

Insured's abuse of Prescription Drugs not taken in accordance with a Physician's Prescription Order.

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

33. 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.

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

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

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; or (ii) mental examinations or psychological tests when there are no symptoms of Mental Illness.

39. Expenses for appointments scheduled and not kept.

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

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

42. 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 as set forth in the Schedule of Benefits. The treatment plan must be specifically authorized in writing by the Company prior to surgery.

43. Expenses for charges incurred with respect to the eye for diagnostic procedures (including, but not limited to: eye refraction; the fitting of eyeglasses or contact lenses; and orthoptic evaluation or training). This exclusion does not apply to lens implants (either donor or artificial) for cataracts, or when required as part of an examination to diagnose an Illness or Injury (other than refractive errors of vision). Such expenses may be considered for Benefits under the vision Policy if that coverage has been selected and premiums have been paid. This exclusion also does not apply to the extent such care is eligible pursuant to the pediatric vision services provisions set forth elsewhere in this Plan.

44. 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.

45. 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.

46. Expenses for:

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

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

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

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

48. 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.

49. Expenses for acupuncture or acupressure.

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

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

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

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

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

55. Expenses for autopsy procedures.

56. Expenses for treatment or services rendered in connection with artificial insemination; invitro fertilization; all procedures to preserve sperm and ova; Prescription Drugs to induce fertility; gamete intrafallopian transfer ("GIFT"); and any other procedures designed to help or treat infertility.

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

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

59. Expenses for massage therapy.

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

61. 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, or other than an abortion performed due to rape or incest.

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

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

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

VI. COBRA, USERRA, COVERAGE DURING DISABILITY, AND EXTENSION OF BENEFITS:

A. **The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"):** If the Insured's Employer employs more than 20 Employees on an average business day during the previous Calendar Year, federal law provides that the Employee and/or his Dependents may be entitled to continue insurance Benefits after termination of group health benefits upon a qualifying event for a period of up to thirty-six (36) months. Some states also require employers with fewer than 20 employees to offer to the insured individuals continuation of their group health coverage. Your Employer can provide you with complete details of the available coverage. WMI Mutual Insurance Company does not assume responsibility for the Employer's duties under COBRA.

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

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

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

When COBRA coverage is available, any person who was on the insurance before termination has the right to select COBRA coverage independently. A newborn Child or a Child placed for adoption during a period of COBRA continuation coverage is also eligible for coverage for the remaining period of the continuation coverage, provided that they are enrolled according to the terms of the Policy. The continuation of coverage provided by the vision and dental plans is optional when the major medical coverage is chosen.

Coverage may be continued for up to 36 months for the spouse and or Dependent Child(ren) if group health coverage is lost due to the Employee's death, divorce, legal separation, the Employee's becoming entitled to Medicare, or because of loss of status as a Dependent Child under the Plan.

Coverage may be continued for up to 18 months if group health coverage terminates due to the employee's termination of employment or reduction in hours. However, there are three exceptions:

1. If an Employee or Dependent is disabled (as determined by the Social Security Administration) at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation period for all qualified

beneficiaries is 29 months from the date of termination of employment or reduction in hours. For the 29-month continuation period to apply, written notice of the determination of disability must be provided to the Employer within both the 18-month coverage period and within 60 days after the date of the determination.

2. If a second qualifying event occurs during the 18-month or 29-month continuation coverage period which would give rise to a 36-month period for the spouse and/or Dependent Child(ren) (for example, the Employee dies or becomes divorced) then the maximum coverage period for a spouse and/or Dependent Child(ren) becomes 36 months from the date of the initial termination of employment or reduction in hours. For the 36-month continuation period to apply, written notice of the second qualifying event must be provided to the Employer within 60 days after the date of the event.
3. If the qualifying event occurs within 18 months after the Employee becomes entitled to Medicare, then the maximum coverage period for the spouse and/or Dependent Child(ren) is 36 months from the date that the Employee became entitled to Medicare.

Premium payments for COBRA continuation coverage for the Employee and for any qualified Dependents for the "initial premium months" are due by the 45th day after electing the continuation coverage. The "initial premium months" are the months that end on or before the 45th day after the election of continuation coverage. All subsequent premiums are due on the first day of the month, subject to a 31-day grace period.

Continuation coverage will automatically terminate when any of the following events occurs:

1. The employer no longer provides group health coverage for any employees.
2. The premium for COBRA coverage is not paid during the required time period.
3. The insured becomes entitled to Medicare.
4. The insured becomes covered under another group health plan with no preexisting condition limitation.
5. The maximum continuation coverage period expires.

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

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

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

The term "uniformed services" means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-

time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

C. **Coverage during Disability:**

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 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 months from the date on which insurance terminated; (ii) until the total maximum amount of Benefits have been paid; (iii) the Employee or Dependent 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.

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

D. **Extension of Benefits:**

1. An individual whose insurance under the group Policy has been terminated, and who has been continuously insured under the group Policy for at least six (6) months prior to termination, has the right to continue coverage under the group Policy for a period of twelve (12) months, unless the Employee (i) was terminated for gross misconduct; or (ii) is eligible for an extension of coverage required by federal law. When applicable, any extension of coverage required by federal law may run concurrently with the requirements of this section. This right to continue coverage includes any Dependent coverage.

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

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

   If the terminated Insured, or with respect to a minor, the parent or guardian of the terminated Insured elects to continue group coverage and tenders to the Employer the amount required within sixty (60) days after the date of termination of the group coverage, coverage of the terminated Insured and coverage of the covered spouse and

Dependents of the terminated Insured continues without interruption and may not terminate unless:

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

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

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

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

(e) The Employer's coverage is terminated.

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

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

A. COORDINATION OF BENEFITS:

1. This Coordination of Benefits (COB) provision applies to this Plan when an Insured also has health care coverage under another plan such as:

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

   (b) Coverage under a governmental plan or required or provided by law, except a state plan under Medicaid or under any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

2. In the event benefits apply under two or more health care plans, the order of benefit determination rules should be consulted and the following provisions shall apply:

   (a) The Benefits under this Plan shall not be reduced when, under the order of benefit determination rules, this Plan determines Benefits before another health care plan, but may be reduced when, under those rules, another health care plan determines its benefits first, whether or not a claim is made under the other health care plan.

   (b) If the other health care plan does not contain a coordination of benefits provision, the benefits of that coverage will be determined before any Benefits under this Plan are determined.

(c) If the other health care plan contains a coordination of benefits provision, the rules establishing the order of benefit determination are as follows:

1. The benefits of the health care plan which covers the person (to whom the claims relate) as other than a Dependents(s), such as an employee, member, policyholder, retiree or subscriber, shall be determined before the benefits of a health care coverage which covers such a person as a Dependent(s).

2. When a Child(ren) is a patient and where the parents are married or living together if they have never been married, the benefits of the health care plan of the parent whose birthday, that is, month and day of the month, falls earlier in a year are determined before those of the health care plan of the parent whose birthday falls later in the year. If the parents have the same birthday, the plan that has covered the Child longer determines benefits first.

   Note: If the other health care plan does not have the rule in section (c)(2) above, but instead has a rule based upon the gender of the parent, and if, as a result, it and this Plan do not agree on the order of benefits, the rule in the other health care plan will determine the order of benefits.

3. When a Child(ren) is a patient and the parents are separated or divorced or are not living together if they have never been married, the following rules apply:

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

      a. Benefits are determined first by the health care plan of the parent with custody of the Child(ren);

      b. Then by the health care plan of the spouse (if any) of the parent with custody of the Child(ren);

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

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

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

4. The benefits of a plan, which covers a person as an active employee who is neither laid off or retired, or as a dependent of an active employee, are determined before those of a plan which cover that person as a retired or laid off employee. If the other health care plan does not have this rule, and if, as a result, there is not an agreement between this Plan and the other health care plan on the order of benefits, this rule is ignored. This section does not apply if the rule in section 2(c)(1) can determine the order of benefits.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan on the basis of their employment, the plan covering the person as an employee, member, subscriber or retiree, or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan, and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan. If the other health care plan does not have this rule, and if, as a result, there is not an agreement between this Plan and the other health care plan on the order of benefits, this rule is ignored. This rule does not apply if the rule in section 2(c)(1) can determine the order of benefits.

6. If the individual is insured under two health plans where none of the above applies, the benefits of the plan which has covered the individual for the longer period of time shall be determined first.

(d) Overpayment: In the event the Company provides Benefit payments to the Insured or on his/her behalf in excess of the amount which would have been payable by reason of coverage under another health care coverage, the Company shall be entitled to recover the amount of such excess from one or more of the persons it has paid or for whom it has paid, insurance companies, or other organizations.

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

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

1. Recovery Rights: The Company shall be entitled to the proceeds of any settlement or judgment which results in a recovery from the third party. This recovery shall be up to

the amount of Benefits paid for the Illness or Injury. This recovery shall apply under the conditions that the Insured is primary and the Company is secondary.

2. If the Insured does not seek recovery from the responsible third party, the Insured shall hold the rights of recovery against the third party in trust for the Company up to the amount of Benefits paid in connection with the Illness or Injury.

3. The Company shall pay out of such proceeds actually recovered a proportionate share of any reasonable expense incurred in collecting from the third party.

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

C. **PERSONS COVERED BY MEDICARE:**

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

   (a) An active Employee who is age sixty-five (65) or older and is with a group of twenty (20) or more Employees, as that term is defined in the Medicare secondary payer rules.

   (b) A Dependent spouse who is age sixty-five (65) or older, of an active Employee who is employed with a group of twenty (20) or more Employees, as that term is defined in the Medicare secondary payer rules.

   (c) The time period required by federal law during which Medicare is the secondary payer to a group health plan and the Insured individual is receiving treatment for end-stage renal disease (ESRD).

2. If the Dependent spouse is also actively employed and enrolled under a group health plan provided by the spouse's Employer, this Plan shall then be secondary to that coverage and Medicare becomes the third payer.

3. This Plan will pay Benefits only after Medicare has paid its Benefits for both of the following:

   (a) For all other Insured persons.

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

VIII. GENERAL POLICY INFORMATION:

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

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

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

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

1. On any premium due date provided the rate for such insurance has been in effect for at least three (3) months. The Company will give written notice to the group Policyholder at least thirty-one (31) days prior to such premium due date.

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

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

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

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

D. **TERMINATION OF POLICY:** If the Policyholder fails to pay any premium within the grace period, this Plan shall automatically terminate on the last day of such grace period. The Policyholder shall be liable to the Company for the payment of all premiums then due and unpaid, including a pro rata premium for the grace period. If the Policyholder gives written notice to the Company that this Plan is to be terminated before the end of the grace period, this Plan shall be terminated on the later of the date of receipt of such notice, or the date specified by the Policyholder. The Policyholder shall be liable to the Company for the payment of all premiums then due and unpaid, including a pro rata premium for the period commencing with the last premium due date and ending with such date of termination.

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

E. **RECORD OF EMPLOYEES INSURED:** The Company shall maintain a record which shall show at all times the names of all Insured Employees, the beneficiary designated by each Employee, if any, the date when each Employee became insured and the Effective Date of any change in coverage. This record shall also show any other information that may be required to administer the insurance. The Company shall furnish a copy of this record to the Policyholder, upon request. The Policyholder shall give the Company any information that is

required for administering the insurance. This information shall include, but is not limited to, information for enrolling Employees, changes in coverage, and termination of insurance. Any records of the Employer and/or Policyholder that may have a bearing on this insurance shall be open for inspection by the Company at a reasonable time.

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

G. **CLAIM AND APPEAL PROCEDURES:**

Following is a description of how the Plan processes claims and appeals. A claim is defined as any request for a Plan Benefit, made by an Insured or a representative of an Insured, that complies with the Plan's procedures for making a claim. There are two types of claims: pre-service and post-service. The different types of claims are described below. Each type of claim has a specific time period for approval, request for further information or denial, as well as specific time periods for appeal reviews. Time periods begin at the time that a claim is filed, and "days" refers to calendar days.

Pre-Service Claim

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

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

Post-Service Claim

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

In the event of a post-service claim, the Insured will receive a notification of the benefit determination within thirty (30) days after the receipt of the request. If additional information is needed, the Insured will be notified within that time and will be given at least forty-five (45) days to respond. A notification of the benefit determination will be sent within fifteen (15) days after the receipt of the additional information.

Notice to Insured of Adverse Benefit Determination

Adverse benefit determination means a denial, reduction, termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan. The plan will provide written or electronic notification that sets forth the reason for the adverse benefit determination.

Appeals

The Plan provides three levels of appeal review, which may be performed either internally or independently, as described herein. The first two levels are required levels that must be exhausted before an Insured can file suit in court. The third level is a voluntary level. In the event of an adverse benefit determination, the Insured has 180 days from the receipt of the adverse benefit determination notification in which to file a first level appeal. An Insured may submit comments, documents, records and other information relating to the claim, and will, upon request, be provided free of charge, access to, and copies of, all documents, records, and other information relevant to the claim that were used in the initial benefit determination. If an Insured receives an adverse decision on the first level of appeal, he may submit the appeal for a second level of review within sixty (60) days of receipt of the first level decision, along with any additional applicable information. In the case of a pre-service claim, each level of appeal will be responded to within fifteen (15) days after the receipt of the appeal. In the case of a post-service claim, each level of appeal will be responded to within thirty (30) days after the receipt of the appeal.

For pre-service claims, both levels of appeal must be submitted in writing to the utilization review company that performed the Pre-certification and a copy must be submitted to the Company. For post-service claims, both levels of appeal must be submitted in writing to the Company. The benefit determination on review will be communicated in writing, and will set forth the reasons for the decision and the provisions of this Plan upon which the decision was based.

Reviews of first and second level appeals of adverse benefit determinations, except those described in the following paragraph, will be conducted internally by a person or a committee of persons who is neither the individual who made the initial adverse benefit determination nor the subordinate of that individual. The time period within which a determination on appeal is required to be made will begin at the time that an appeal is filed.

Independent, External Review for First and Second Level Appeals - If the appeal of an adverse benefit determination is based on a medical judgment, including determinations with

regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, an independent review will be conducted. For this review, the plan will consult with an independent health care professional, who is not affiliated with the Company, who was not involved in the initial benefit determination, and who has appropriate training and expertise in the field of medicine involved in the medical judgment. There will be no fee charged to the Insured for an independent review.

If an Insured receives an adverse decision upon the exhaustion of both of the required levels of internal or independent review, he has the right to file suit in court pursuant to §502 of the Employee Retirement and Income Security Act ("ERISA").

Third Level Appeal – External Independent Review - If an Insured receives an adverse benefit determination on the second level of appeal, and the appeal is based on medical necessity, appropriateness of care, or experimental/investigational services, he may appeal to the third **voluntary** level by submitting a written request within four (4) months from the receipt of the determination notification, along with any additional applicable information. The Insured may also appeal to the third voluntary level if the Plan has exceeded the timelines for response without good cause and without reaching a decision. The appeal will be reviewed by an Independent Review Organization ("IRO") assigned by the state. The Insured and the treating provider will be notified in writing of the IRO's decision within forty-five (45) days after receipt of the request for review. There will be no fee charged to the Insured for an independent review.

Expedited External Independent Review: An Insured may request an expedited external independent review if the final internal adverse benefit determination (i) concerns an admission, availability of care, continued stay, or health care service for which the Insured received emergency services but has not been discharged from a facility; or (ii) involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the Insured or jeopardize the Insured's ability to regain maximum function. The IRO must make its decision to uphold or reverse the final internal adverse benefit determination and notify the Insured and the Company as expeditiously as possible but no later than seventy-two (72) hours after it receives the request for expedited review.

H. **CONFORMITY WITH LAW:** If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

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

In any Calendar Year in which there are surplus earnings as a result of favorable claims experience, and the Board of Directors in its discretion determines that it is appropriate and advisable to return the surplus earnings to the Policyholders, such earnings will be refunded to eligible Employers as an experience rating refund. The method and timing of the refund is

determined by the Company's Board of Directors. To be eligible to participate in the refund, a participating Employer must be a Policyholder at the time the refund is made.

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

K. **ANNUAL MEETING:** The annual meeting of the Company shall be held on the first Friday in December of each year at the home office of the Company.

L. **ENTIRE CONTRACT:** This Plan and all attachments hereto, the application of the Policyholder, and individual applications and the enrollment cards of Insured Employees constitute the entire contract between the parties. All statements made by the Policyholder or by the insured Employees and their Dependents shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Employee or his Dependents shall affect the insurance or be used in defense to a claim hereunder unless such statement is formalized in writing and a copy of the instrument containing such statement is, or has been furnished to such Employee or to his beneficiary.

M. **AMENDMENT AND ALTERATION OF CONTRACT:** This Plan may be amended at any time, subject to the laws of the jurisdiction in which it is delivered. The Plan may be amended by written agreement between the Policyholder and the Company without the consent of the Insured Employees or their beneficiaries. This Plan may also be amended on the Plan's renewal date upon sixty (60) days written notice from the Company to the Policyholder. If an Insured is confined in a Hospital or Extended Care Facility on the effective date of the amendment, Benefits shall not be affected until the date of discharge. No change in the Plan shall be valid until approved by a duly authorized officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change any Plan or waive any provision thereof.

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

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

O. **EXAMINATION:** The Company shall have the right and opportunity to have the person of any individual whose Injury or Illness is the basis of a claim examined when and so often as

it may reasonably require during pendancy of claim hereunder. The Company shall also have the right and opportunity to make an autopsy in the case of death where it is not forbidden by law.

P. **PAYMENT OF CLAIM:** Upon request of the Insured Employee and subject to due proof of loss, the accrued daily Hospital Benefits will be paid each week during any period for which the Company is liable and any balance remaining unpaid at the termination of such period will be paid promptly upon receipt of due proof. Any other Benefits provided in the Plan will be paid promptly after receipt of due proof.

All Benefits are payable to the Employee or his legal assignee. If any such Benefits remain unpaid at the death of the Employee, if the Employee is a minor, or if the Employee is, in the opinion of the Company, legally incapable of giving a valid receipt and discharge for any payment, the Company may, at its option, pay such Benefit to the Employee's legal heirs. Any payments made will constitute a complete discharge of the Company's obligations to the extent of such payment and the Company will not be required to see the application of the money so paid.

Q. **MEDICAL RECORDS:** The Company shall have the right to request and receive, without cost or expense, medical records relating to care and treatment of any Insured who claims Benefits under this Plan, prior to paying any Benefits under this Plan. The Insured does fully authorize, empower, and direct his Provider to furnish the Company with such complete reports and medical records when he requests any Benefits.

R. **OVERPAYMENTS:** If for any reason the Company pays any amount to, or on behalf of, the Insured:

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 Company may, at its discretion, recover overpayments from one or more of the persons it has paid or for whom it has paid. The Company may also recover overpayments from future claims payments to the same provider for services rendered to the same Insured.

S. **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.

T. **TIME LIMITATION:** If any time limitation of the Plan with respect to giving notice of claim, furnishing proof of loss, or bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Policy is delivered, such limitation shall be extended to agree with the minimum period permitted by such law.

U. **INTERPRETATION:** Whenever the context of this Plan requires, the singular shall include the plural, the plural shall include the singular, the whole shall include any part thereof, and

any gender shall include both genders. The captions which precede parts of this Plan are for reference only and shall not affect the manner in which any provision hereof is construed. Words that are capitalized throughout this document shall have the meaning prescribed to them in the Definitions section of this document.

The following paragraph does not apply to plans that are not subject to ERISA. The following paragraph only applies to plans that are subject to ERISA:

The Company shall have the sole discretion to construe and interpret the terms and provisions of the Plan and to determine eligibility for benefits. Nothing in the foregoing statement limits the rights of the Insured to protections under the federal law known as ERISA, including, but not limited to, rights of appeal and rights to bring suit in state or federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when an Insured seeks judicial review. The court will determine the level of discretion that it will accord to the Company's determinations.

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

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

X. **RIGHTS UNDER ERISA:** If the Insured has any questions about the Plan, he or she should contact the Company. If the Insured has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), he or she should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

X. PRIVACY POLICY

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

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

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

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

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

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

WMI Mutual Insurance Company

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