ARIZONA GROUP HEALTH INSURANCE PLAN
CERTIFICATE BOOKLET

(amendments 1-5 incorporated)

1500 (60/40) Plan

WMI Mutual Insurance Company

PO Box 572450
Salt Lake City, UT 84157
(800) 748-5340 (801) 263-8000
Fax (801) 263-1247

Schedule of Benefits

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

1. **Individual and Family Annual Deductible:**

(a) **Annual Deductible (Per Person): 1500 Plan: $1500**

(1) Except as specifically set forth in this Schedule of Benefits or the Policy, the Insured and each covered Dependent must satisfy the individual Annual Deductible before any benefits under this Policy are paid.

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

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

2. **Percentage payable after satisfaction of Deductible and prior to the satisfaction of the Out-of-Pocket maximum amounts for eligible Inpatient Hospital, Outpatient Hospital, Surgical and Medical services:**

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

(b) **Non-PPO Network Percentage Payable After Deductible** (unless otherwise specified in the Policy or in this Schedule of Benefits): **40%**

(c) **Pre-Deductible Benefit for Eligible Charges For All Covered Medical Services (except for Prescription Drugs that are covered elsewhere in the Policy under the optional Prescription Drug card rider):**

All medical services covered under this Policy (except for Prescription Drugs that are covered elsewhere in the Policy under the optional Prescription Drug card rider) are not subject to the Calendar Year Deductible unless and until the Company has paid a total of **$500** toward these services. The percentage payable for these services is as described elsewhere in this Schedule of Benefits for each corresponding service. Amounts paid by the Insured for these services prior to the satisfaction of the $500

Benefit do not apply toward the satisfaction of the Deductible amount. Amounts paid by the Insured for services for Inpatient and outpatient treatment of Mental Illness, Inpatient and outpatient treatment of alcohol dependency or substance abuse, organ transplants and implants, and Medically Necessary surgery for temporomandibular joint syndrome ("TMJ") also do not apply toward the satisfaction of the Out-of-Pocket amounts.

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

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

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

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

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

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

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

(4) Routine childhood immunizations:

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

(5) Influenza immunizations:

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

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

(1) Category I organ transplants and joint implants as defined in the Policy are subject to the General Limitations and Exclusions applicable to major medical expense Benefits and Preexisting Condition sections. Category I organ transplants and joint implants must be pre-authorized by the Company in writing. The allowable amount for Implantable Hardware used for a joint implant is limited to the invoice cost, plus 50%, as set forth elsewhere in the Schedule of Benefits. An invoice showing the actual cost of the implant must be submitted to the Company. Eligible diagnostic, medical and surgical expenses for a compatible live or cadaveric donor, that are directly related to the transplant, are paid to a maximum payment amount of **$20,000** per organ, provided that the recipient of the transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under a recipient's coverage (even if both the donor and the recipient are Insureds under this Plan). Donor charges are ineligible for Benefits if the recipient is not an Insured under this Plan.

(2) Category II organ transplants as defined in the Policy are deemed to be Preexisting Conditions unless sufficient documentation is produced to indicate otherwise. Category II organ transplants are only considered for benefits after the eligible Employee or Dependent has been insured under the Plan for a period of twelve (12) consecutive months (eighteen (18) months for a Late Enrollee). This waiting period, which applies regardless of whether the condition is a Preexisting Condition, shall be reduced by the number of days of Creditable Coverage calculated as of the Enrollment Date of the patient. Category II organ transplants must be pre-authorized by the Company in writing, and may require a consistent second opinion, (and third opinion), if requested by the Company. All pre-authorized Category II organ transplants are paid to a lifetime maximum payment of **$250,000** per organ. For the purpose of this Benefit, any transplant therapy or protocol involving bone marrow shall constitute one organ even if multiple transplants are performed. This maximum allowable amount includes payment for all transplant related costs including, but not limited to, all hospital, surgical, and medical expenses for an eligible transplant. Eligible diagnostic, medical and surgical expenses for a compatible live or cadaveric donor, that are directly related to the transplant, are paid to a maximum payment amount of **$20,000** per organ, provided that the recipient of the transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under a recipient's coverage (even if both the donor and the recipient are Insureds under this Plan). Donor charges are ineligible for Benefits if the recipient is not an Insured under this Plan. The maximum amount payable for eligible donor charges will be applied to the lifetime maximum amount payable for the transplant. A period of

eighteen (18) months must transpire before a benefit shall be allowed for a different eligible Category II organ transplant.

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

(g) **Ambulance Services:**

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

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

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

(h) **Durable Medical Equipment:** Except as set forth below, eligible expenses are paid at **50%** not to exceed a maximum payment of **$3,000** per Calendar Year, and are subject to all other Policy provisions including, but not limited to, Usual and Customary allowances or PPO network allowances.

1. Eligible expenses for insulin pumps, pain management pumps and infusion-type pumps will be paid at **50%** not to exceed a maximum payment of **$7,500** per Calendar Year. This limit applies regardless of whether the pumps are internal or external.

2. Eligible expenses for pacemakers are not subject to the limits as set forth above and are paid at the levels as for any other major medical expense.

(i) **Prosthetics:** For a natural limb or eye which is lost while insured, only the initial prosthesis is eligible for payment at **50%** to a maximum payable amount of **$5,000**.

(j) **Mammograms:**

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

Subject to the following guidelines:

(1) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.

(2) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's Physician.

(3) A mammogram every year for any woman who is fifty (50) years of age or older.

(4) A mammogram for any woman desiring a mammogram for medical cause.

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

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

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

(n) **Treatment for Diabetes:** Expenses related to diagnosis, monitoring, treatment, control, and education for self-management of diabetes, such as education and medical nutrition therapy, medicines, equipment and supplies are paid at **60%**. **Note:** Equipment that meets the definition of Durable Medical Equipment will be paid in accordance with the Durable Medical Equipment benefit as described elsewhere in this Schedule of Benefits.

(o) **Colonoscopy:**

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

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

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

2. Once every five (5) years beginning at age 40 if colorectal cancer or adenomatous polyps were present in any first-degree relative (parent, sibling, or child) before the relative's age of 60, or in two or more first-degree relatives at any age.

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

(p) **Office Visits:**

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

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

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

3. **Annual Out-of-Pocket:**

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

1500 Plan: $3,000

(1) Except as set forth in this Schedule of Benefits or in the Policy, eligible charges will be paid at **100%** by the Company during any Calendar Year in which the applicable Out-of-Pocket amounts have been satisfied. Only Deductible and co-insurance amounts (except co-insurance amounts paid towards Prescription Drugs or for any Benefits which are not eligible to be paid at 100%) that are paid by the insured person during the Calendar Year will be applied toward the satisfaction of the Individual Annual Maximum Out-of-Pocket. Amounts paid for non-covered care or treatment and office visit co-payments do not apply toward the Individual Annual Maximum Out-of-Pocket.

(2) Benefits for Prescription Drugs will always be paid in accordance with the Prescription Drug Card Rider, if the optional Prescription Drug Card Rider has been elected and premiums have been paid, regardless of whether the Individual Annual Maximum Out-of-Pocket amount has been satisfied.

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

1500 Plan: $6,000

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

in accordance with the Prescription Drug Card Rider, if the optional Prescription Drug Card Rider has been elected and premiums have been paid, regardless of whether the Individual Annual Maximum Out-of-Pocket amount has been satisfied.

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

B. **OPTIONAL PRESCRIPTION DRUG CARD RIDER**:

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

1. **Deductible Per Person** (the Prescription Drug Deductible is waived for generic drugs, except on the high deductible health plan)**:**

1500 Plan: $250

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

Generic: $10 or 25% (whichever is greater)
Brand: $50 or 50% (whichever is greater)

3. **Annual Prescription Drug Maximum (per person):**

1500 Plan: $50,000

C. **MENTAL ILLNESS CARE AND TREATMENT OF ALCOHOL DEPENDENCY OR SUBSTANCE ABUSE (for Employers with 2-50 Employees):**

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

1. **Inpatient Mental Illness Care:**

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

Eligible expenses are paid at up to a maximum of fifteen (15) days each Calendar Year. There is no 100% Benefit at any time, nor is this Benefit increased after the satisfaction of the Out-of-Pocket amounts.

2. **Outpatient Mental Illness Care:**

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

Eligible Outpatient visits are limited to twenty (20) visits per Calendar Year. There is no 100% Benefit at any time, nor is this Benefit increased after the satisfaction of the Out-of-Pocket amounts.

3. **Inpatient treatment of Alcohol Dependency or Substance Abuse.** Eligible expenses are paid at **50%** and are covered to a maximum of **$2,000** in a twelve (12) month period, with a lifetime maximum of **$5,000**. There is no 100% Benefit at any time, nor is this Benefit increased after the satisfaction of the Out-of-Pocket amounts.

4. **Outpatient Treatment of Alcohol Dependency or Substance Abuse.** Eligible expenses are paid at **50%** and are subject to a maximum yearly Benefit of **$1,000**. There is no 100% Benefit at any time, nor is this Benefit increased after satisfaction of the Out-of-Pocket amounts.

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

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

Option I

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

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

Inside PPO Network: 60%

Outside PPO Network: 40%

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

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

Option II*:

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

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

TABLE OF CONTENTS **Page**

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 (including a Child(ren) of a non-custodial parent), legal adoption as of the date of placement for adoption, legal (court appointed) guardianship, a Child(ren) for whom coverage must be provided pursuant to a court or administrative order, or other Child(ren), who is a Dependent of the Employee as that term is defined in this Policy.

"Company" means WMI Mutual Insurance Company.

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

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

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

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

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

"Creditable Coverage" means Plan participants will be given "credit" toward the satisfaction of any Preexisting Condition Limitation period for the length of coverage under any of the following plans: (a) group health insurance; (b) Individual health insurance; (c) Medicare and Medicaid; and (d) Government programs such as, public health plans, state high risk pools, or military plans. The exclusion for Preexisting Conditions will be reduced by the number of months that the Employee has remained covered under any of these plans. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the Enrollment Date, there was a period of sixty-three (63) days or more during all of which the individual was not covered under any Creditable Coverage. This sixty-three (63) day period shall not include any period that an individual is in a Waiting Period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period.

"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) unmarried Child(ren), under age nineteen (19) years of age **(Note: Your Employer may have chosen a different maximum age requirement than this one. Please verify your company's specific requirements with WMI;)**

(c) The Insured Employee's (or the Insured Employee's Spouse's) unmarried Child(ren), under age twenty-three (23) years of age, who is a full-time student and who is financially dependent on the Insured* **(Note: Your Employer may have chosen a different maximum age requirement than this one. Please verify your company's specific requirements with WMI;)**

***Exception:** if a Dependent child student takes a Medically Necessary leave of absence, or changes to part-time status, as a result of serious Illness or Injury, coverage may be continued until 1) the date that is one year after the first day of the leave of absence, or 2) the date of which such coverage would otherwise terminate under the terms of this Plan. For this exception to apply, the Dependent Child student must have been enrolled in the Plan immediately before the first day of the leave of absence, and the Plan must receive a written certification by a treating physician which states that the Dependent Child student is suffering from a serious Illness or Injury.

(d) A Child who has reached the limiting age for termination of coverage, but who is Disabled and dependent upon the Insured, provided that the Child was enrolled in this Plan at the time of reaching the limiting age.

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

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

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

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

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

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

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

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

"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 the sudden onset of a medical condition manifesting itself by acute symptoms that are severe enough that (1) the lack of immediate medical attention could result in (a) placing the person's health in jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part; or (2) a reasonable person believes that immediate medical attention is required.

"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 one-hundred twenty (120) hours per month and who receives compensation for his services from the Employer **(Note: Your Employer may have chosen different minimum hourly requirements than those listed above. Please verify your company's specific requirements with WMI.)** An Employee of the subsidiaries and affiliates, if any, of the Employer named on the face of this Plan, shall be deemed an Employee of the Employer and service with any such subsidiaries and affiliates shall be deemed service with the Employer, if in compliance with hours worked. For the purpose of this definition, an owner, sole proprietor, partner, officer or director shall be considered an "Employee" provided that he or she is Actively at Work as set forth herein.

"Employer" or **"Participating Employer"** means any corporation or proprietorship operating as a business entity, that is a member of a *bona fide* association that contracts with the Company to provide insurance Benefits to its membership, that has eligible

Employees insured with the Company, who has agreed in writing to become a Policyholder of the Company.

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

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

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

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

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

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

"Home Health Care" means services provided by a licensed home health agency to an Insured in his place of residence that is prescribed by a licensed Physician as part of a written plan of care. Home Health Care coverage includes: nursing; home health aide services; physical therapy; occupational therapy; respiratory therapy; speech therapy; and medical supplies, drugs, medicines, and laboratory services, to the extent that they would have been covered if provided on an inpatient Hospital basis

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

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

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

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

(d) Qualifies as a reimbursable service under Medicare.

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

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

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

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

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

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

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

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

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

"Late Enrollee" means an individual who enrolls under the Plan at a time other than during the period in which the individual was first eligible, including an individual who enrolls during the Open Enrollment period. A Late Enrollee is not an individual who enrolls in accordance with the Special Enrollment provisions of this Plan.

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

"Maximum Lifetime Benefit" means the maximum benefit payable by WMI to any insured individual during their lifetime regardless of the named policyholder. This includes any amounts payable pursuant to COBRA, state extension of benefits, and conversion provisions. For conversion provisions, benefits payable during the first year of the conversion policy, together with the benefits paid for the individual under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force.

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

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

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

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

(c) not only for the convenience of the Insured or Provider or any other person's convenience.

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

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

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

"Mental Illness" means any mental condition or disorder that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically

revised. Mental Illness does not include the following when diagnosed as the primary or substantial reason or need for treatment: marital or family problem; social, occupational, religious, or other social maladjustment; conduct disorder; chronic adjustment disorder; psychosexual disorder; chronic organic brain syndrome; personality disorder; specific developmental disorder or learning disability; or mental retardation.

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

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

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

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

"Owner" means an owner, partner or proprietor of the Policyholder. In order to be eligible for the optional 24-hour coverage, 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. A Physician is classified as a practitioner of the healing arts.

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

"Policyholder" means the Employer named on the Certificate.

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

"Practitioner" means an individual who is licensed by the state to provide medical or surgical services, which are similar to those provided by Physicians. Practitioners include practitioners of the healing arts, podiatrists, chiropractors, doctors of oriental medicine, optometrists, psychologists, certified midwives, registered lay 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.

"Preexisting Condition" is a physical or mental condition, regardless of the cause of the condition, for which medical advice, care or treatment was recommended or received within the six (6) months prior to the Enrollment Date. The term "Preexisting Condition" does not include pregnancy and does not include genetic information in the absence of a diagnosis of the condition related to such information.

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

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

"Prescription Drug" means a drug or medicine which can only be obtained by a Prescription Order and bears the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription" or other similar type of wording, or which is restricted to prescription dispensing by state law. The term Prescription Drug **does not** include insulin, diabetic testing equipment, supplies for insulin, and prescription drugs for genetic inborn errors of metabolism, 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 screening/pap smears, and prostate tests.

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

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

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

"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.

"Supplemental Accident Expense" means expenses for Medically Necessary services incurred as a result of, and within ninety (90) days of, an Accidental Bodily Injury, where the first treatment is rendered within forty-eight (48) hours of the Accidental Bodily Injury.

"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 this policy.

A. **ELIGIBILITY DATE FOR EMPLOYEES OF NEWLY ENROLLED EMPLOYER GROUPS:** Employees who worked an average of thirty (30) hours or more in each week of the preceding month are eligible to participate in the Plan on the Effective Date of the Employer's Plan **(Note: Your Employer may have chosen different average hourly requirements than those listed above. Please verify your company's specific requirements with WMI.)** Employees must enroll in the Plan prior to the Employer's Effective Date. Employees must submit an enrollment card that has been properly completed to the Company in order to enroll. 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 first day of the month following the later of the following events:

1. The date that the Employer's eligibility requirements and Waiting Period are satisfied.

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

3. Thirty-one (31) days after their date of hire (if they did not maintain other health insurance coverage as of their date of hire).

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

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

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

C. **ELIGIBILITY DATE FOR DEPENDENTS:** Eligible Dependents must submit a properly completed enrollment card to the Company in order to enroll in the Plan. Eligible Dependents who enroll at the same time as the Employee can participate in this Plan on the same day as the Employee. An eligible Dependent who does not enroll at the same time as the Employee cannot enroll in the Plan until the next Open Enrollment period, unless they are a Special Enrollee.

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 become effective on the first day of the first calendar month following the date that the enrollment materials are received by the Company.

1. Employees who declined participation in the Plan when they were first eligible because they maintained other health insurance and have since involuntarily lost the other coverage. If the other coverage is provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Employee may only enroll after the COBRA coverage has been involuntarily exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, 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, for whom the application and approval procedures for adoption pursuant to A.R.S. 8-105 or 8-108 have been completed, 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. Eligible Employees or Dependents who are not enrolled in this Plan may enroll upon becoming eligible for a premium assistance subsidy under Medicaid or SCHIP. The Employee or Dependent must request enrollment within sixty (60) days after eligibility for the subsidy is determined.

E. **MAINTENANCE OF EMPLOYEE ELIGIBILITY:** 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 a minimum of one-hundred twenty (120) hours in each month while receiving compensation for such service from the Employer. Eligibility may also be maintained if the Employee is on paid leave status of not more than six (6) months. The Employee must have worked a minimum of one-hundred twenty (120) hours during the two (2) months immediately preceding the date he was placed on leave status **(Note: Your Employer may have chosen different minimum hourly requirements than those listed above. Please verify your company's specific requirements with WMI.)**

F. **MAINTENANCE OF GROUP ELIGIBILITY:** This Plan may be terminated if the number of the Employees that are insured with the Company is less than 50% of those that are eligible for the insurance. The Company requires that 100% of all of the Employees participate if there are less than three (3) Employees that are eligible for the insurance. The Company requires that 75% of all of the Employees participate if there are less than ten (10) Employees that are eligible for the insurance. This Plan may be terminated on any premium due date for failure to meet the participation requirements. This will be done by giving written notice to the Policyholder at least thirty-one (31) days in advance.

III. TERMINATION OF INSURANCE BENEFITS:

A. TERMINATION OF EMPLOYEE COVERAGE:

1. An Employee's insurance under this Plan will terminate on the last day of the month in which he no longer qualifies as an eligible employee. An Employee's insurance under this Plan will also terminate on the last day of the month in which he leaves the employ of the participating Employer. The insurance for Dependents will terminate if the Employee's insurance terminates. When applicable, coverage may be continued after that time as set forth in Section VII of this Policy.

2. If the required monthly premiums are not timely received by the Company, coverage will automatically be terminated as of the end of the last day for which a premium has been paid. The coverage for a terminated group may be allowed to be reinstated if all of the requirements of the Company have been met. All premiums are due on the first day of each calendar month. All premiums 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. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties. Any person who 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:** Coverage for the Dependent shall automatically terminate on the earliest of the following dates.

1. The date that the covered Dependent ceases to be eligible as a defined "Dependent". When applicable, coverage may be continued after that time as set forth in Section VII of this Policy.

2. The date that the Employee's coverage under the Plan terminates. When applicable, coverage may be continued after that time as set forth in Section VII of this Policy.

3. The date of the expiration of the period for which the last premium is made for 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 under this Plan may also be immediately terminated if he has made an intentional misrepresentation of material fact under the terms of the coverage. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties. Any person who 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 for each of his Dependent(s) shall be continued in force until the last day of the month for which the premium was paid. When applicable, coverage may be continued after that time as set forth in Section VII of this Policy.

2. In the event that the Employee becomes insured under Medicare, the coverage for each of his Dependent(s) may be extended if they are eligible. Please refer to the applicable part of Section VII of this Policy.

3. If an Employee's covered Dependent(s) is incapable of self-support because of mental retardation or physical handicap on the date his coverage would otherwise terminate on account of age, and within thirty-one (31) days of that date the Employee submits to the Company satisfactory proof of his incapacity, his medical Benefits will be continued during the period of his incapacity. The Company may subsequently require proof of his incapacity, but not more frequently than annually after the two (2) year period following the Dependent's attainment of the limiting age. This extension will continue until the earliest of:

   (a) The date he ceases to be incapacitated;

   (b) The thirty-first (31^{st}) day after the Company requests additional proof of his incapacity if the Employee fails to furnish such proof; or

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

IV. COVERED SERVICES:

This Policy provides the following Benefits as set forth in the Schedule of Benefits.

A. **INPATIENT FACILITY SERVICES:** The length of time of all Inpatient facility stays must be Pre-Certified to determine their Medical Necessity. 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 prior to all Inpatient facility admissions that are not emergencies. Emergency admissions must be reported within twenty-four (24) hours of the admission (or on the next business day if the admission occurs on a weekend or holiday). Failure to comply will reduce all Benefits for the Inpatient facility stay by 10%. **Pre-certification does not guarantee that payment will be made nor does it determine that Benefits are eligible**. An Insured may contact the Pre-certification company to request a review if he receives an adverse determination, in which Benefits are denied in whole or in part. The review will be conducted in accordance with the provisions that are established by applicable law.

1. Inpatient Hospital Daily Rate (other than Intensive Care Unit). The daily Hospital room rate to the extent that the charge does not exceed the Hospital's most common charge for its standard Semi-private room accommodations. The Plan limits Hospital stays to a maximum duration of three hundred sixty-five (365) days for each Disability.

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

3. Inpatient Hospital Intensive Care Unit. Eligible expenses that are incurred in a Hospital Intensive Care Unit are covered up to a maximum of one hundred eighty (180) days per Disability.

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

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

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

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

C. **OUTPATIENT TREATMENT FOR MENTAL ILLNESS:** Outpatient Mental Illness care expenses that are eligible are covered as set forth in the Schedule of Benefits. Care must be rendered by a Mental Health Care Practitioner or in a Mental Health Care Facility as 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 TREATMENT FOR ALCOHOL DEPENDENCY OR SUBSTANCE ABUSE:** Outpatient expenses that are eligible are covered as set forth in the Schedule of Benefits. Treatment must be rendered in an Alcohol/Substance Abuse Dependency Treatment Center 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.

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

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

2. Multiple or Bilateral Surgical Procedures. When multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same time and through the same incision, the available Benefits shall be the value of the major procedure plus 50% of the value of the lesser procedure. The available Benefit for multiple procedures that are performed through separate incisions or in separate sites 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 an additional Benefit is not available.

3. The Plan also covers one co-surgeon for each surgery. The services must be Medically Necessary. The co-surgeon must also be licensed under a different specialty than the primary surgeon. The total allowable amount is limited to 125% of the primary surgeon's allowance. That amount will be split equally between the primary surgeon and the co-surgeon.

F. **MEDICAL SERVICES:**

1. Physician Consultations:

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

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

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

(d) Concurrent Physicians Services:

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

(ii) A patient who is admitted to the Hospital for a medical condition and is then transferred to the Hospital's surgical service for the same condition but under the care of another Physician, is entitled to Hospital Physician Benefits only from the date of admission to the date of transfer to the surgical service. After that time, 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 the services of more than one Physician were required due to the medical complexity of the patient's condition, the services provided by the additional Physician will be covered.

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

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

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

5. The Plan covers back and spine manipulations and modalities as set forth in the Schedule of Benefits.

6. The Plan covers Hospital inpatient care following a lumpectomy, a mastectomy, or a lymph node dissection. Coverage shall be up to forty-eight (48) hours for inpatient care following a mastectomy and shall be up to twenty-four (24) hours for inpatient care following a lymph node dissection.

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

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

"Reconstructive breast surgery" means surgery performed as a result of a mastectomy to establish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

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

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

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

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

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

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

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

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

means a substance which increases the reproduction, differentiation, and maturation of blood cellular components.

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

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

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

J. **ANESTHESIA SERVICES:** The Plan covers anesthesia service that is performed in order to achieve general or regional (but not local) anesthesia. The service must be at the request of the attending Physician. The service must be performed by a Physician other than the operating Physician or the Assistant. The services of a nurse anesthetist who is not employed by the Hospital and who bills for services rendered 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.

K. **MATERNITY SERVICES:**

1. Benefits for maternity are paid as any other Illness for a Dependent spouse or a female Employee. Maternity coverage does not include an Insured's Dependent Child or a Dependent Child's spouse. 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. A Hospital length of stay in excess of forty-eight (48) hours following a normal vaginal delivery or in excess of ninety-six (96) hours following a cesarean section shall be covered if it is determined to be Medically Necessary by the attending physician. It is recommended, although it is not required, that the expectant mother call the Pre-certification company during the first trimester so that a review for a possible high risk pregnancy can be performed.

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

3. Maternity Benefits apply to the costs of the birth of a Child who is legally adopted by the Insured if all of the following are true:

(a) The Child is adopted within one year of birth;

(b) The Insured is legally obligated to pay the costs of birth;

(c) All Preexisting Conditions and other limitations have been met and all Deductibles and copayments have been paid by the Insured;

(d) The Insured has notified the Company of the Insured's acceptability to adopt Children pursuant to A.R.S. 8-105 within sixty (60) days after this approval or within sixty (60) days after a change in insurance policies, plans or companies.

This coverage is in excess of any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to A.R.S. Title 36, Chapter 29, but not including coverage made available to persons defined as eligible under A.R.S. 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

If other coverage exists, the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent.

The Insured adopting parents shall notify the Company of the existence and extent of the other coverage.

The Company is not required to pay any costs in excess of the amounts it would have been obligated to pay to Hospitals and Providers if the natural mother and Child had received the maternity and newborn care directly from or through the Company.

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

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

1. A Provider's professional and surgical services are covered.

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

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

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

5. Physical therapy that is rendered by a Provider operating within the scope of their license is covered. Physical therapy must be Medically Necessary and is subject to all other policy provisions.

6. Orthopedic braces are covered. Shoes or related supportive or corrective devices, including orthotics, are not covered (unless they are provided in connection with the treatment of diabetes).

7. The 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 the maintenance of any items purchased under this section.

8. Prosthetics for artificial limbs or eyes are covered. Only the initial prosthetic device is eligible for payment, unless the initial device is no longer serviceable and it cannot be made serviceable. Prosthetics for Injuries or Illnesses that happened prior to the Effective Date of coverage will be subject to the Preexisting Condition limitation.

9. Home Health Care is covered if provided in lieu of, and not to exceed the cost of, confinement in a Hospital or Skilled Nursing Facility. Home Health Care must be provided by a licensed home health agency, in the Insured's place of residence, and must be rendered based on the written order of a licensed Physician, provided such order is renewed at least every thirty (30) days. Home Health Care coverage includes:

   (a) Services provided by a registered nurse (RN) or licensed practical nurse (LPN);

   (b) Home health aide services;

   (c) Physical therapy;

   (d) Occupational therapy;

   (e) Respiratory therapy;

   (f) Speech therapy; and

   (g) Medical supplies, drugs, medicines, and laboratory services, to the extent that they would have been covered if provided on an inpatient Hospital basis.

10. Ambulance is covered if the services are reasonably necessary for an Accident or an Illness. The services must be provided to the nearest Hospital providing the level of care that is needed.

11. Cardiac rehabilitation therapy, such as, but not limited to, the use of common exercise equipment while under a Physician's care is covered. The therapy must

take place in a formal rehabilitation program at an accredited facility. The therapy must also be prescribed by a Physician. This Benefit is limited to a maximum of $500 for each occurrence. The therapy must be rendered within ninety (90) days following a cardiac Illness or a surgery in order to be eligible.

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

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

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

15. The Plan covers treatment for genetic inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. Eligible expenses are covered at **50%** to a maximum of **$5,000** per Calendar Year. Coverage shall include nutritional and medical assessment, including clinical services, biochemical analysis, medical supplies, Prescription Drugs, corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and special medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

    Special medical foods are nutritional substances in any form that are (i) formulated to be consumed or administered internally under the supervision of a Physician; (ii) specifically processed or formulated to be distinct in one or more nutrients present in natural food; (iii) intended for the medical and nutritional managements of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and (iv) essential to optimize growth, health and metabolic homeostasis.

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

17. 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 provided that the optional Prescription Drug Card rider has been elected and premiums have been paid. Prescription Drugs purchased through the optional Prescription Drug Card rider do not apply to the major medical Deductible or the Out-of-Pocket maximum. If the optional Prescription Drug card rider has been elected and premiums have been paid, Prescription Drugs not purchased through the Prescription Drug Card Benefit will be paid as set forth in the Schedule of Benefits upon submission to the

Company. Mail order drugs are only covered if purchased through the optional Prescription Drug Card rider. An equivalent Generic Drug must be used whenever one is available. If a brand name drug is purchased instead of a generic equivalent, the Insured is responsible for the price difference. In accordance with the Policy provisions for determining medical necessity, some Prescription drugs are subject to maximum dispensing limitations at either a retail pharmacy or through the mail order program. These limits are based on clinically approved prescribing guidelines and are regularly reviewed to ensure medical necessity and appropriateness or care. Prescription drugs that exceed the manufacturer's recommended dosage or the dosage established by the Food and Drug Administration ("FDA") are not covered. There are no Benefits for Prescription Drugs if the optional Prescription Drug Card rider has not been selected.

Drugs and medicines that require a Prescription Order that have not been approved for use by the FDA for the specific condition for which they are being prescribed, but have been approved for use by the FDA for another condition, are eligible for Benefits if it is determined that they have been recognized as medically appropriate and effective for the treatment of the specific condition for which they are being prescribed in one or more of the following medical reference publications: the American Hospital Formulary Services Drug Information; the National Comprehensive Cancer Network Drugs and Biologics Compendium; Thomson Micromedex Compendium DrugDex; Elsevier Gold Standard's Clinical Pharmacology Compendium; and other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services. 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.

18. Expenses for sleep studies and expenses for the treatment of sleep apnea are covered. This Benefit is payable as set forth in the Schedule of Benefits. Treatment to diagnose and to correct snoring is not covered.

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

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

21. When prescribed or diagnosed by a health care Practitioner, all individuals with diabetes shall be entitled to the following:

    (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 blood glucose monitors, which include test strips whose performance achieved clearance by the FDA for marketing;
    (d) visual reading and urine testing strips, which includes visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones;
    (e) lancet devices and lancets for monitoring glycemic control;
    (f) insulin, which includes commercially available insulin preparations, including insulin analog preparations available in either vial or cartridge;
    (g) injection aids, including those adaptable to meet the needs of the legally blind, to assist with insulin injection;
    (h) syringes, which includes insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin devices and other disposable parts required for insulin injection aids;
    (i) insulin pumps, which includes insulin infusion pumps;
    (j) medical supplies for use with insulin pumps and insulin infusion pumps to include infusion sets, cartridges, syringes, skin preparation, batteries and other disposable supplies needed to maintain insulin pump therapy;
    (k) medical supplies for use with or without insulin pumps and insulin infusion pumps to include durable and disposable devices to assist with the injection of insulin and infusion sets;
    (l) prescription oral agents or each class approved by the FDA for treatment of diabetes, and a variety of drugs, when available, within each class;
    (m) Medically Necessary podiatric appliances for the prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment;
    (n) glucagon emergency kits; and
    (o) any other device, medication, equipment or supply for which coverage is required under Medicare.

22. Diabetes self-management training and patient management, including medical nutrition therapy, when deemed Medically Necessary and prescribed by an attending Physician.

23. Expenses for prescription contraceptive drugs or devices that have been approved by the Food and Drug Administration are covered if the Optional Prescription Drug Card Rider has been selected and premiums have been paid. Treatment or services rendered in connection with the placement of such drugs or devices is covered, subject to Deductible and coinsurance amounts that are consistent with those for other similar expenses under this Policy.

24. Emergency care, as defined in the Policy, that is rendered by a non-Preferred Provider, and where the Insured could not reasonably reach a Preferred Provider, will be reimbursed as though the Insured had been treated by a Preferred Provider.

25. Covered Expenses that are directly associated with a phase I, II, III, or IV cancer clinical trial that is offered in the state of Arizona and in which the Insured participates voluntarily. Any Benefits under this Plan shall not supplant any portion of the clinical trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry resources. Coverage will be provided **if** the following criteria are met:

    a) The clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention and is for the prevention of reoccurrence, early detection, treatment or palliation of cancer in humans and in which the scientific study includes all of the following: 1) specific goals; 2) a rationale and background for the study; 3) criteria for patient selection; 3) specific direction for administering the therapy or intervention and for monitoring patients; 5) a definition of quantitative measures for determining treatment response; and 6) methods for documenting and treating adverse reactions.
    b) The clinical trial is being conducted with approval of at least one of the following: 1) one of the federal national institutes of health; 2) a federal national institutes of health cooperative group or center; 3) the federal department of defense; 4) the federal food and drug administration in the form of an investigational new drug application; 5) the federal department of veterans affairs; or 6) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility.
    c) The proposed clinical trial or study has been reviewed and approved by an institutional review board that has an active federal-wide assurance of protection for human subjects.
    d) The personnel providing the clinical trial or conducting the study 1) are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise; and 2) agree to accept reimbursement as payment in full from the health plan at the rates that are established by that plan and are not more than the level of reimbursement applicable to other similar services provided by health care providers within the plan's provider network.
    e) There is no non-investigational treatment equivalent to the clinical trial.
    f) The available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative.

26. The Plan covers amino acid-based formula that is ordered by a Physician provided that 1) the Insured has been diagnosed with an eosinophilic gastrointestinal disorder; 2) the Insured is under the continuous supervision of a Physician; and 3) there is a risk of a mental or physical impairment without the use of the formula. Eligible expenses are covered at **75%** to a maximum of **$20,000** per Calendar Year.

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

V. GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL BENEFITS:

There are no Benefits available under this Policy for the following services.

1. Expenses for care or services provided before the Insured's Effective Date or after the termination date of the Insured's coverage are not covered.

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 are not covered. 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 are not covered.

4. Expenses for which payment has been made under automobile or vehicle medical payment provisions when such coverage is in force are not covered. Credit will be applied towards the Deductible and Out-of-Pocket amounts under this Policy after such expenses have been paid by the automobile or vehicle medical payment coverage. The Company must receive proof of such payment before credit will be applied.

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 or Illness caused by, or arising out of the following is not covered: 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 are not covered. This exclusion also applies to services, supplies, or accommodations that are provided due to a court order, whether or not Illness or Injury is involved.

8. Expenses for treatments or procedures that are Experimental or Investigational are not covered. This exclusion also applies to any related services, supplies, or accommodations for these treatments or procedures.

9. Expenses in connection with transplants are not covered (except as specifically set forth in the Schedule of Benefits). This exclusion applies whether the Insured is the donor or is the recipient.

10. Expenses for care, treatment or operations which are performed primarily for Cosmetic purposes are not covered. Expenses for complications of such procedures are also not covered. This exclusion does not apply when expenses are incurred as a result of an Injury as long as the expenses are incurred within one (1) year of the date of Injury. This exclusion also does not apply when expenses are incurred for reconstructive surgery following a mastectomy, or for the repair of a congenital anomaly. The Preexisting Condition limitation applies to any exception to this general exclusion.

11. Expenses for treatment of obesity or for weight reduction are not covered. 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 a reversal of a gastric or intestinal bypass, balloon implant, gastric stapling, or other similar surgical procedure are not covered.

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 are not covered.

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

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

17. Care or treatment is not covered for marital or family problems; for a behavior disorder; for chronic situational reactions; or for social, occupational, religious or other social maladjustment, including drugs for the same.

18. Expenses are not covered for milieu therapy; for modification of behavior; for biofeedback; or for sensitivity training.

19. Care or treatment is not covered for psychosexual identity disorder; for transsexualism; for sexual transformation; or for psychosexual dysfunction.

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

21. Expenses are not covered for the easing of chronic, intractable pain by a pain control center or under a pain control program to the extent that those expenses exceed the Usual and Customary expenses for Semi-private room accommodations.

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

23. Expenses for the reversal of surgically performed sterilization are not covered.

24. Expenses for rest cures are not covered.

25. Expenses in connection with institutional care that are, as determined by the Company, for the primary purpose of controlling or changing the environment of the Insured are not covered.

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

29. Expenses are not covered for services that are incurred for intentional self-destruction or self-Injury or any attempt at self-destruction. This exclusion does not apply if the Injury is the result of an act of domestic violence. This exclusion also does not apply if the Injury is the result of a medical condition (including both physical and mental health conditions).

30. Expenses are not covered for an Illness or Injury that is the result of 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 or his guardian is not legally obligated to pay are not covered.

33. Expenses for any service associated with pregnancy are not covered. This exclusion does not apply if the patient is the female Insured Employee or the spouse of a male Insured Employee.

34. Expenses for any services or products unless the services or products are both of the following.

    (a) Medically Necessary.

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

35. Expenses for training, educating, or counseling a patient are not covered. This exclusion does not apply when such services are rendered, without a separate expense, in connection with other Covered Services. This exclusion also does not apply when the services are Medically Necessary and when they are specifically prescribed by a Physician.

36. Expenses for a private school; a public school; or a halfway house are not covered.

37. Expenses that are associated with speech therapy are not covered. This exclusion does not apply when such services are required to restore to function speech loss or impediments due to Illness or Injury. Expenses for such services must be incurred within one (1) year of the date of the onset of the Illness or the date of Injury. The Preexisting Condition limitation applies to the exception to this general exclusion.

38. Expenses for transportation are not covered (except ambulance services that are Medically Necessary as set forth in the Schedule of Benefits). This exclusion includes, but is not limited to, 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.

39. Expenses that are 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.

40. Expenses are not covered for (i) Routine Physical Examinations which exceed the guidelines set forth in this Policy or the Schedule of Benefits; (ii) x-ray or laboratory

procedures when there are no symptoms of Illness or Injury, unless they are covered as part of the Routine Physical Examination Benefit; or (iii) mental examinations or psychological tests when there are no symptoms of Mental Illness.

41. Expenses for preventative medical care are not covered (except as specifically set forth in the Schedule of Benefits).

42. Expenses for appointments that are scheduled and are not kept are not covered.

43. Expenses for telephone consultations, whether they are initiated by the Insured or the Provider are not covered.

44. Expenses are not covered for the care and treatment of: teeth; gums; or alveolar process; dentures; dental appliances; or supplies used in such care and treatment except as specifically provided for by the terms of the Plan or in the Schedule of Benefits. Such expenses may be considered for Benefits under the dental Policy if that coverage has been selected and the premiums have been paid.

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

46. 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.

    In the event surgical treatment is deemed Medically Necessary and in accordance with accepted medical practice as determined by the Company, Benefits will be allowed at **50%** provided that the treatment plan is specifically authorized in writing by the Company prior to surgery. There is no 100% coverage at any time.

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

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

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

50. Expenses are not covered for the following.

    (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 the fitting of supportive devices, including orthotics (this exclusion does not apply to eligible expenses that are provided for the treatment of diabetes).

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

51. Expenses for corrective shoes (unless they are an integral part of a lower body brace) or for special shoe accessories are not covered. This exclusion does not apply to eligible expenses that are provided for the treatment of diabetes.

52. 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 are not covered.

53. Expenses for acupuncture and acupressure are not covered.

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

55. Expenses for preventative medication; vitamins; food supplements; sports therapy equipment, and services and applications of such are not covered.

56. Expenses for anabolic steroids; weight-reduction drugs; growth hormones; and non-prescription hematinics are not covered.

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

58. Expenses for experimental drugs; for non-legend drugs; for anti-wrinkle agents; and for Tretinoin, all dosage forms (for example, Retin A) for Insureds over twenty-five (25) years of age are not covered.

59. Medicines that, by a law of the United States, require a Physician's Prescription are not covered (except for insulin, testing supplies, and syringes for diabetes, and prescription drugs for genetic inborn errors of metabolism). This exclusion does not apply if the optional Prescription Drug card rider has been elected and premiums have been paid.

60. Expenses for autopsy procedures are not covered.

61. Expenses for treatment or services rendered in connection with the removal of contraceptive devices; for artificial insemination; for invitro fertilization; for all procedures to preserve sperm and ova; for Prescription Drugs to induce fertility; for

gamete intrafallopian transfer ("GIFT"); and for any other procedures designed to help or treat infertility.

62. Expenses are not covered for the care or treatment of an elective surgery; for complications of an elective surgery; or for complications of an ineligible procedure.

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

64. Expenses that are related to treatment for infertility including Prescription Drugs and medications are not covered.

65. Expenses for massage therapy are not covered.

66. All shipping, handling, delivery, sales tax, or postage charges are not covered. This exclusion does not apply if the charges are incidentally provided in connection with Covered Services or supplies.

67. Expenses for an elective abortion are not covered. This exclusion includes any medications and Prescription Drugs that are for the purpose of inducing abortion. An "elective abortion" means an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.

68. Expenses that are incurred as the result of the Insured or any insured person committing a fraudulent insurance act are not covered.

69. Care that is rendered outside of the United States, except Urgent Care or Emergency care is not covered.

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

71. 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. PREEXISTING CONDITIONS:

A. **PREEXISTING CONDITIONS:** During the six (6) months following the Enrollment Date (eighteen (18) months for a Late Enrollee), no Benefits will be provided under this agreement for any of the following; however, this time period will be reduced by the number of days of Creditable Coverage calculated as of the Enrollment Date of the Insured:

1. A Preexisting Condition as defined in this Policy.

The Company will not deny, exclude, or limit Benefits for a covered individual for losses incurred more than six (6) months (eighteen (18) months for a Late Enrollee) following the Enrollment Date of the individual's coverage due to a Preexisting Condition.

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

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

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

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

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

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

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

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

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

1. If an Employee or Dependent is disabled (as determined by the Social Security Administration) at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation period for all qualified beneficiaries is 29 months from the date of termination of employment or reduction in hours. For the 29-month continuation period to apply, written notice of the determination of disability must be provided to the Employer within both the 18-month coverage period and within 60 days after the date of the determination.

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

3. If the qualifying event occurs within 18 months after the Employee becomes entitled to Medicare, then the maximum coverage period for the spouse and/or Dependent Child(ren) is 36 months from the date that the Employee became entitled to Medicare.

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

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

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

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

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

When an Insured Employee loses coverage under the group health Plan because the Employee leaves work to perform military service, and the group health Plan is subject to COBRA, the Employee and the Employee's Dependents will be entitled to protections of both COBRA and USERRA. When the requirements of COBRA 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 that 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 are 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, including the Conversion Plan of this Company.

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

D. **Conversion Plan:** An Employee and that Employee's Dependents whose insurance under the group Policy has been terminated due to the termination of the Employee's

employment have the right to be covered under the Company's conversion plan when the group coverage terminates. If the Insured exercises this conversion option, he may waive his right to insurability under the federal Health Insurance Portability and Accountability Act of 1996. (P.L. 104-191).

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

1. To the surviving Spouse and, at the option of the Spouse, to the Child(ren) for whom the Spouse has responsibility for care and support, at the death of the Employee;

2. To the Spouse of the Employee upon termination of the coverage of the Spouse by reason of divorce, annulment, or legal separation;

3. To a Child upon termination of the coverage of the Child by reason of the Child ceasing to be a qualified Dependent.

An individual does not have conversion rights if:

1. Termination of the group coverage occurred because of failure of the Employee to pay any required individual premiums;

2. The Insured acquires other group health coverage that is comparable to the coverage under the conversion plan;

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

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

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

VIII. COORDINATION OF BENEFITS 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) Group insurance or group-type coverage, whether insured or uninsured, including prepayment, group practice or individual practice coverage. This also includes coverage for students other than school accident-type coverage, or HMO plans, or individual plans; 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) 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 not separated or divorced, 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)(1) and (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, the following rules apply:

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); and

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

Note: If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child(ren), and the entity obligated to pay or provide the benefits of the health care plan of that parent has actual knowledge of those terms, the benefits of that health care plan are determined first. If the parent with financial responsibility has no coverage for the Child's health care services or expenses, but that parent's spouse does, the benefit of that health care plan are determined first. This does not apply with respect to any claim determination period or year during which benefits are actually paid and provided before the entity has that actual knowledge. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expense of the Child, the order of benefits determination rules outlined in the Arizona Code shall apply.

4. When a Child(ren) is a patient and the parents are not married or are separated, whether or not they ever were married, or are divorced, and there is no court decree allocating responsibility for the Child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses, if any, is:

   a. The health care plan of the parent with custody of the Child(ren).

   b. The health care plan of the spouse of the parent with custody of the Child(ren).

   c. The health care plan of the parent not having custody of the Child(ren).

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

5. The benefits of a plan, which covers a person as an active employee, member or subscriber, are determined before those of a plan which cover that person as an inactive employee, member or subscriber. 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.

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. **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 that is provided by the spouse's Employer, this Plan shall then be secondary to that coverage and Medicare becomes the third payer.

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

   (a) For all other Insured persons.

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

IX. GENERAL POLICY INFORMATION:

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

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

2. The number of Insured Dependents, if any, in each classification multiplied by the applicable rate for each person. This will be based on the classifications as determined by the premium rates that are 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 as long as 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 sixty (60) days prior to such premium due date.

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

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

B. **PAYMENT OF PREMIUMS:** All premiums that are due under this Plan, and any adjustments, are payable by the Policyholder on or before their respective due dates. Premiums are payable 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 that immediately precedes 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 that are then due and unpaid. This amount includes any 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 that is specified by the Policyholder. The Policyholder shall be liable to the Company for the payment of all premiums that are then due and unpaid. That amount shall include a pro rata premium for the period starting with the last premium due date and ending with such date of termination.

E. **RECORD OF EMPLOYEES INSURED:** The Company shall maintain a record which shall show at all times the names of all Insured Employees, the beneficiary designated by each Employee, if any, the date when each Employee became insured and the Effective Date of any change in coverage. This record shall also show any other information as 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 to administer the insurance. This 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 has the discretion to interpret this Policy and to resolve and interpret any ambiguities. The Company will issue a Certificate directly to the Insured Employee. The Certificate may also be issued to the Policyholder, is appropriate, to deliver to each Insured Employee. The Certificate shall describe the Policy Benefits and to whom the Benefits will be paid. The Certificate shall also describe any Policy limitations or requirements that will have an effect on 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 the Plan and the Certificate of insurance conflict, the terms of the Plan shall govern.

G. **CLAIM AND APPEAL PROCEDURES:** Following is a description of how the Plan processes claims and appeals. At the time of enrollment, each Insured Employee will also be provided with a "Health Care Insurer Appeals Process Information Packet" that describes the procedures to follow to appeal an adverse benefit determination.

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 received, 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 Plan Participant. 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. In the event of an adverse benefit determination, the plan will provide a written or electronic notification that sets forth the reason for the adverse 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 two (2) years from the receipt of the 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, both the first and second levels of appeal will be responded to within fifteen (15) days after the receipt of the appeal. In the case of a post-service claim, both the first and second levels of appeal will be responded to within thirty (30) days after the receipt of the appeal.

Reviews of first and second levels of appeals, 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 received.

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

If an Insured receives an adverse benefit determination on the second level of appeal, he may appeal to the third **voluntary** level by submitting a written request within thirty (30) days from the receipt of the determination notification, along with any additional applicable information. Within five (5) business days of receiving the request, the appeal will be sent to the Arizona Director of Insurance. If the appeal 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, the Director will forward the appeal within five (5) days of their receipt to an independent review organization for review. The independent review organization will make a decision and will notify the Director within twenty-one (21) days. The Director will then notify the Insured within five (5) business days of receiving that decision. If the appeal is based on an issue of contract coverage, the Director will make a decision and notify the Insured within fifteen (15) business days of receiving the appeal. **Note:** Third level appeals cannot be accepted for issues regarding deductible amounts, co-insurance levels, or usual and customary amounts.

For pre-service claims, first level appeals may be submitted orally or in writing to the utilization review company that performed the Pre-certification and a copy must be submitted to the Company; all other 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, first level appeals may be submitted orally or in writing to the Company; all other 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.

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").

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 to that law.

I. **EXPERIENCE RATING REFUNDS:** This Plan shares in the surplus earnings of the Company. Surplus earnings are defined as the amount of earnings in excess of earnings that are required to maintain minimum compulsory surplus required by law.

Surplus earnings are also defined as the amount required to maintain an appropriate level of financial reserve as determined by the Board of Directors in its sole discretion.

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

J. **NON-ASSESSABLE PLAN:** If for any reason the Company is unable to maintain the required reserves or to pay justified claims, Benefits may be reduced in accordance with an equitable plan that is 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 a 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 an Extended Care Facility on the effective date of the amendment, Benefits shall not be affected until the date of the discharge. No change in the Plan shall be valid until it is approved by a duly authorized officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has the authority to change any Plan or to waive any of its provisions.

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 patient. 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 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 the 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. 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 the Company may, at its option, pay such Benefit to the Employee's legal heirs. The Company may also, at its option, pay such Benefit to the Employee's legal heirs 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. 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. **MEDICAID PAYMENTS:** Benefits that have been paid on behalf of a Child(ren) or any other Insured person will be paid to the human services department when (i) the human services department has paid or is paying benefits on behalf of the Child(ren) or other Insured person under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, *et. seq.*; (ii) payment for the services in question has been made by the human services department to the Medicaid provider; and (iii) the insurer is notified that the Insured individual receives benefits under the Medicaid program and that benefits must be paid directly to the human services department.

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

S. **OVERPAYMENTS:** If for any reason the Company pays any amount to or on behalf of the Insured for (i) services not covered under this Plan; (ii) for services

which exceed the amounts to be paid as Benefits under this Plan; or (iii) for services on behalf of a person who is 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 made to the same provider for services that are rendered to the same Insured.

T. **LEGAL PROCEEDINGS:** No action of law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

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

V. **INTERPRETATION:** Whenever the context of this Plan requires, the singular shall include the plural, the plural shall include the singular, the whole shall include any part thereof, and any gender shall include both genders. The captions which precede parts of this Plan are for reference only and shall not affect the manner in which any provision is construed. Words that are capitalized throughout this document shall have the meaning that is prescribed to them in the Definitions section of this document.

The Company shall have the sole discretion to construe and interpret the terms and provisions of the Plan and to determine the eligibility for benefits. Nothing in the foregoing statement limits the rights of the Insured to the 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.

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

X. **PREFERRED PROVIDER ORGANIZATION ("PPO"):** Eligible Benefits that are obtained from a preferred provider 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. Eligible Benefits for a non-preferred provider will be processed according to the usual and customary rate and will be reimbursed at a lower percentage level.

Y. **RIGHTS UNDER ERISA:** If the Insured has any questions about the Plan, he or she should contact the Company. If the Insured has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act ("HIPAA"), he or she should contact the nearest area office of the

Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, at 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

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

PO Box 572450
Salt Lake City, UT 84157
(801) 263-8000 & (800) 748-5340
FAX (801) 263-1247