ARIZONA GROUP HEALTH INSURANCE PLAN
CERTIFICATE BOOKLET

WMI Mutual Insurance Company

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TABLE OF CONTENTS **Page**

I. DEFINITIONS: The following terms are defined for guidance only and do not create coverage.

"Accident" or **"Accidental Bodily Injury"** means a physical Injury that is sustained by an unexpected occurrence. The Injury must be independent of a disease or a bodily infirmity. The Insured must not be entitled to receive any Benefits under any worker's compensation law or an occupational disease law. Physical damage that results from a normal body movement such as stooping, bending, twisting, or chewing is not considered to be an Accident.

"Actively at Work" and **"Active Work"** means being in attendance in person at the usual and customary place or places of business and acting in the performance of the duties of the occupation of the Employee on a full time basis. An Employee shall be deemed to be Actively at Work on each day of a regular paid vacation if he/she was Actively at Work on the last preceding regular work day. An Employee shall also be deemed to be Actively at Work 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, if 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 as long as work begins before the coverage becomes effective.

"Alcohol/Substance Abuse Dependency Treatment Center" means a treatment facility that is licensed or is 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 the injured and that is staffed with appropriately certified or licensed personnel. An Ambulance must be equipped with emergency medical care and supplies. An Ambulance must be equipped with equipment such as oxygen, a defibrillator, splints, bandages, adjunctive airway devices, and devices to carry patients.

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

"Benefits" means the payments that are provided for the Insured Employee or the 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). Brand Drugs are also 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 that is prepared by the Company, and includes all riders and supplements, if any. The Certificate sets forth a summary of the insurance to which an Employee and his Dependents are entitled. The Certificate also sets forth 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.

"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 any federal extension of Benefits.

"Cosmetic" or "Cosmetic Surgery" means any surgical procedure that is performed to improve appearance or to correct a deformity but that does not restore a physical bodily function. Psychological factors, such as poor body image and difficult peer relations, are not considered to be a bodily function, and they do not establish medical necessity.

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

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

"Custodial Care" means services, supplies or accommodations for care which meet any of the following.

(a) They do not provide treatment of an Injury or an Illness.

(b) They could be provided by persons who do not have professional skills or qualifications.

(c) They are provided primarily to assist the Insured in daily living.

(d) They are for convenience, contentment or other purposes that are not therapeutic.

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

"Date Incurred" means the date that services were provided.

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

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

(a) The lawful spouse of an Insured Employee.

(b) The Insured Employee's (or the Insured Employee's Spouse's) Child(ren) until the attainment of age twenty-six (26).

(c) A Child who has reached the limiting age for termination of the coverage and who is Disabled and dependent upon the Insured. The Child must have been enrolled in this Plan at the time of reaching the limiting age.

"Disability or Disabled" as that term is applied to Employees, means the continuing inability of the Employee to perform the duties related to his employment for which he is otherwise qualified in a substantial manner because of an Illness or an Injury. The term **"Disability or Disabled,"** as that term is applied to Dependents, means 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 requirements listed below.

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

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

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

(d) It is prescribed by a Physician or a 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 it pertains to the Employer's Plan, means the date the Employer's Plan becomes in force. As it pertains to the Employee or Dependent, the term "Effective Date" shall mean the date that the Employee or Dependent becomes insured.

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

"Emergency" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

"Employee" means any person who is in an Employee/Employer relationship and who is Actively at Work. An Employee must work a minimum of one hundred twenty (120) hours per month and must receive 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, shall be deemed to be an Employee of the Employer. Service with any such subsidiaries and affiliates shall be deemed to be service with the Employer, if it is in compliance with hours worked. For the purpose of this definition, an owner, a sole proprietor, a partner, an officer or a director shall be considered to be an "Employee" as long as 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. An Employer is one that is a member of a *bona fide* association that contracts with the Company to provide insurance Benefits to its membership. An Employer is one that has eligible Employees that are insured with the Company, and that 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 for 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. They must be accepted as a valid course of treatment by the U.S. Food and Drug Administration, the American Medical Association, the Surgeon General, or any other medical society that is recognized by the Company. Any services, supplies, or accommodations that are provided in connection with such procedures are included in this definition.

"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). This care is provided to individuals who are convalescing from an Injury or an 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 to be an "Extended Care Facility/Rehabilitation Care Facility."

"Family Deductible" means three (3) times the individual Deductible amount. 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 amount. An individual family member may not contribute more than one-half of the Family Out-of-Pocket maximum. 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 Deductible and co-insurance amounts that are paid by the Insured during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Amounts that are paid for care or treatment that is not covered 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). Generic Drugs are also multisource products that have lower costs than Brand Drugs, and are no longer protected by patents.

"Home Health Care" means services that are provided by a licensed home health agency to an Insured in his place of residence. These services are prescribed by the Insured's attending 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, and speech therapy. Services also include 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 that operates within the scope of such license. A Hospice provides palliative care and treatment of patients with a life expectancy of six (6) months or less. The focus of the care and treatment is the acknowledgement of death and dealing with it in both its physical and psychological aspects. Such services are covered if the Hospice meets all of the following criteria.

(a) It is engaged in providing nursing services and other medical services under the supervision of a Physician.

(b) It maintains a complete medical record on each patient.

(c) It is not engaged in providing Custodial Care, care or treatment of Mental Illness, or care or treatment for drug or alcohol abuse or dependency.

(d) It qualifies as a reimbursable service under Medicare.

"Hospital" means a facility which is licensed and accredited by the Joint Commission on Accreditation of Hospitals. Such facility must operate within the scope of its license. Such facility must make use of at least clinical, laboratory, and diagnostic x-ray services. Such facility must also make use of 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 that results from a disease, a sickness, or a malfunction of the body. Illness also mean a congenital malformation which causes functional impairment. The Employee or the Dependent(s) must not be entitled to receive any Benefits under any workers' compensation law or an occupational disease law.

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

"Injury" means an Accidental Bodily Injury that is sustained by the Insured person which is the direct result of an Accident. Injury is independent of a disease or a bodily infirmity or any other cause. The Insured must not be entitled to receive any Benefits under any workers' compensation law or an occupational disease law for such Injury.

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

"Insured" means the Insured Employee or the 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 to enroll. Late Enrollee includes 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.

"Medicaid" means the programs that provide Hospital and medical Benefits under Title XIX of the Federal Social Security Act as it is now in effect or as it is amended hereafter.

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

(a) They are consistent with the symptom(s) or the diagnosis.

(b) They are received in the most appropriate, cost effective, setting that can be used safely.

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

(d) They are appropriate with regard to the standards of good medical practice in the state and could not have been omitted without adversely affecting the condition of the Insured or the quality of the medical care that was received.

"Medicare" means the programs that provide Hospital and medical Benefits under Title XVIII of the Federal Social Security Act as it is now in effect or as it is hereafter amended. Employees and Dependent(s) who are eligible for any coverage under Medicare shall be deemed to have all of the coverage that is 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. Such facility must provide a program for the treatment of Mental Illness pursuant to a written plan.

"Mental Health Care Practitioner" means an individual who is licensed by the state as a Physician or a surgeon, or an osteopathic Physician and who is 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 in order to retrain the patient in work activities (school, home management, and employment). Occupational Therapy is directed toward the coordination of finer, more delicate movements, such as coordination of the fingers, to the sick or injured person's highest attainable skills.

"Office Visit" means: (1) an evaluation, a consultation, or a physical examination that is performed by a medical doctor (M.D.), a doctor of osteopathy (D.O.), or a nurse practitioner (N.P.); (2) an initial psychiatric evaluation **only** when it is conducted by a provider licensed to perform that evaluation; and (3) an initial evaluation **only** when it is 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. The term Office Visit also includes Home Health Care services.

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

"Out-of-Pocket" means the maximum dollar amount per year of Eligible Charges that are payable by an Insured to Providers. An individual family member may not contribute more than one-half of the Family Out-of-Pocket maximum. Prescription Drug costs do not apply to the Out-of-Pocket maximum amount. Only Deductible and eligible 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.

"Owner" means an owner, a partner or a 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 does not have such insurance in effect.

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

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

"Policyholder" means the Employer.

"Practitioner" means an individual who is licensed by the state to provide medical or surgical services which are similar to those that are 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 a Hospital confinement is Medically Necessary and that the proposed length of stay is appropriate. **Pre-certification does not guarantee the payment of claims. Pre-certification also does not determine whether Benefits are eligible.** Although recommended, Pre-certification for Urgent Care is **not** required. However, once the care is no longer Urgent Care, Pre-certification requirements will apply.

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

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

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

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

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

"Provider" means a Hospital, a skilled nursing facility, an ambulatory service facility, a Physician, a Practitioner, or other individual or organization. A provider must be 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. This includes general supervision and the daily awareness of resident functioning and continuing needs.

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

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

(e) Health related services. This includes services, other than medical services, that pertain to general supervision, protective, and preventive services.

This definition does not include a nursing care institution. This definition also does not include a Hospital, a Mental Health Care Facility, a Chemical Dependency Treatment

Center, or an 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 an Illness or an Injury. Routine Physical Examination includes the examination and the routine lab procedures that are required for the examination. Such procedures include, but are not limited to, cytological screening/pap smears, and prostate tests.

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

"Semi-private Room 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 the 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 that are incurred as a result of an Accidental Bodily Injury. Services must be incurred within ninety (90) days of the Accident. The first treatment must be rendered within forty-eight (48) hours of date of the Accident.

"Telehealth" means the interactive use of audio, video or other electronic media, including asynchronous store-and-forward technologies and remote patient monitoring technologies, for the purpose of diagnosis, consultation or treatment. Telehealth includes the use of an audio-only telephone encounter between an Insured who has an existing relationship with a health care Provider if both of following apply: (a) an audio-visual Telehealth encounter is not reasonably available due to the Insured's functional status, the Insured's lack of technology or telecommunications infrastructure limits, as determined by the health care Provider; and (b) the Telehealth encounter is initiated at the request of the Insured or authorized by the Insured before the Telehealth encounter. Telehealth also includes the use of an audio-only encounter between the Insured and the health care Provider, regardless of whether there is an existing relationship, if the Telehealth encounter is for a behavioral health or substance use disorder and the requirements in (a) and (b) above apply.

Telehealth does not include the sole use of a FAX machine, instant messages, voice mail or email.

"Total Disability" means the inability to perform the duties of any gainful occupation for which the Insured is reasonably fit to perform 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 applying the time periods that are used for making decisions that are not for Urgent Care could seriously jeopardize the insured's life, health or ability to regain maximum function. Urgent Care also means medical care or treatment where applying the time periods that are used for making decisions that are not for Urgent Care would subject the insured to severe pain that cannot be adequately managed without the care or treatment, in the opinion of a Physician with knowledge of the insured's medical condition. The determination of whether care is Urgent Care can also 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.

"Usual and Customary" means the charge that is associated with a medical or surgical supply, a service, a procedure or a Prescription Drug which represents the normal charge level for that procedure in the geographic area of service. For the purpose of air Ambulance services, the Usual and Customary amount shall be limited to 250% of the amount that is allowed by Medicare.

"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 those terms are defined in the policy.

A. **ELIGIBILITY DATE FOR EMPLOYEES OF NEWLY ENROLLED EMPLOYER GROUPS:** Employees are eligible to participate in the Plan if they worked an average of thirty (30) hours or more per week during the prior month **(Note: Your Employer may have chosen different average hourly requirements than those listed above. Please verify your company's specific requirements with WMI.)** Employees are eligible to participate on the Effective Date of the Plan of the Employer. Employees must enroll in the Plan prior to the Effective Date of the Employer. Employees must submit an Enrollment card that has been completed properly to the Company. An Eligible Employee cannot enroll in the Plan until the next Open Enrollment period if he does not enroll prior to the Effective Date of the Plan of the Employer.

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

1. If the Employer has selected a Waiting Period of 60 days or less, coverage will become effective on the first day of the month that <u>follows</u> the satisfaction of such Waiting Period.

2. If the Employer has selected a Waiting Period of 90 days, coverage will become effective on the first day of the month that precedes the satisfaction of such Waiting Period.

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

For the 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 an enrollment card that has been completed properly to the Company to enroll in the Plan. Eligible Dependents can participate in this Plan on the same day as the Employee if they enroll at the same time as the Employee. An Eligible Dependent cannot enroll in the Plan until the next Open Enrollment period if he does not enroll at the same time as the eligible Employee. This does not apply if the Dependent is a Special Enrollee.

D. **SPECIAL ENROLLEES:** The following individuals are eligible to enroll in the Plan outside of the Open Enrollment period. An enrollment card that has been completed properly must be submitted to the Company within thirty-one (31) days of eligibility. Coverage will be effective on the first day of the first calendar month that follows the date that the enrollment materials are received by the Company.

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

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

3. Dependents of Employees who are Insured under the Plan, who declined to participate in the Plan when they were first eligible because they maintained other health insurance and they have since lost the other coverage. If the other coverage is COBRA coverage, the Dependent may only enroll after the COBRA

coverage has been exhausted. If the other coverage was provided through Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, the coverage through this Plan must be requested within sixty (60) days after the termination. An individual who voluntarily cancels other health coverage or ceases to pay premiums for such other coverage is not eligible for special enrollment rights and must wait until the Open Enrollment period to enroll.

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

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

   b. A newborn Child is automatically covered from the moment of birth for a period of thirty-one (31) days. 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. The Insured Employee must enroll the eligible Child within thirty-one (31) days from the date of the birth or the placement for adoption. If the payment of a specific premium is required to provide coverage for a newborn or adopted Child. The Insured Employee must pay all applicable premium within the thirty-one (31) day period in order for the coverage of a newborn or an 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 if they become eligible for a premium assistance subsidy through 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 they are 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 prior to 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 the number 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. The Company may terminate this Plan for failure to meet the participation requirements on any renewal date. The Company will give written notice to the Policyholder at least thirty-one (31) days in advance.

III. TERMINATION OF INSURANCE BENEFITS:

A. TERMINATION OF EMPLOYEE COVERAGE:

1. The insurance for an Employee under this Plan will terminate on the last day of the month in which the Employee no longer qualifies as an eligible Employee. The insurance for an Employee under this Plan will also terminate on the last day of the month when he/she leaves the employ of the Participating Employer. The insurance for the Dependents will terminate if the insurance for the Employee terminates.

2. If the required monthly premiums are not received on time by the Company, coverage will be automatically terminated as of the end of the last day for which premium has been paid. Reinstatement of the coverage for a terminated insurance group may be allowed if all of the requirements of the Company have been met. All premiums are due on the first day of each calendar month. Premiums shall be considered delinquent on or before the 10th day of the month that such premiums are due.

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

B. **TERMINATION OF DEPENDENT COVERAGE:** The coverage for a Dependent shall automatically terminate on the earliest of the dates that follow.

1. The date that the covered Dependent ceases to be eligible as a “Dependent” as defined in the Policy.

2. The date that the coverage for the Employee under the Plan terminates.

3. The date that the period for which the last premium is paid for an Employee’s Dependent Coverage expires.

4. The insurance for a Dependent under this Plan may terminate immediately if he has performed an act or practice that constitutes fraud. The insurance for a Dependent may also be terminated if he has made an intentional misrepresentation of material fact under the terms of the coverage. The Company will give a 30-day advance notice to the Insured prior to such rescission or termination. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false

information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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

1. Coverage for Dependents shall be continued in force until the last day of the month for which the premium was paid in the event of the death of the Employee.

2. If a covered Dependent of an Employee is incapable of self-support because of intellectual Disability or a physical handicap on the date his coverage would otherwise terminate on account of age, the medical Benefits will be continued during the period of his incapacity. Satisfactory proof of the incapacity must be submitted to the Company within thirty-one (31) days from the date the coverage would otherwise terminate. The Company may subsequently require proof of his incapacity as specified in the Plan. This extension will continue until the earliest of the following dates.

   (a) The date he ceases to be incapacitated.

   (b) The thirty-first (31st) day after the Company requests additional proof of his incapacity, if the Employee fails to furnish such proof.

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

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

A. **INPATIENT FACILITY SERVICES:** The Medical Necessity of the length of stay of all Inpatient facility confinements must be Pre-Certified. Pre-certification is recommended for Urgent Care but it is **not** required. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. The company that must be contacted for Pre-certification is shown on the insurance card. They must be contacted before all Inpatient facility admissions that are not emergencies. Emergency admissions must be reported within twenty-four (24) hours of the admission, or as soon as reasonably possible. Benefits will be reduced for the Inpatient facility confinement by 10% for failure to comply. **Pre-certification does not guarantee that payment will be made nor does it determine that Benefits are eligible.** If an Insured receives an adverse Pre-certification determination in which Benefits are denied in whole or in part, he may contact the Pre-certification company to request a review. The review will be conducted in accordance with the provisions that are established in the Claim and Appeal Procedures section set forth elsewhere in the Policy.

1. **Inpatient Hospital Daily Rate (other than Intensive Care Unit).** The daily Hospital room rate is covered 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.** The treatment must be rendered in a licensed facility, such as, but not limited to, a psychiatric special hospital or a general Hospital in order to be eligible for Benefits. Treatment rendered must also meet all other criteria for eligibility and is 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.** The treatment must be rendered in a licensed facility, such as, but not limited to, a psychiatric special hospital or a general Hospital in order to be eligible for Benefits. Treatment must also meet all other criteria for eligibility and is 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 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 it is not eligible for Benefits.

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

C. **OUTPATIENT TREATMENT FOR MENTAL ILLNESS:** Eligible outpatient care must be rendered by a Mental Health Care Practitioner or in a Mental Health Care Facility as those terms are defined in the Policy in order to be eligible for Benefits. Treatment rendered must also meet all other criteria for eligibility and is 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:** Eligible treatment must be rendered by a Provider or a Practitioner or in an Alcohol/Substance Abuse Dependency Treatment Center as those terms are defined in the Policy in order to be eligible for Benefits. Treatment must also meet all other criteria for eligibility and is subject to all other terms and provisions of the Policy in order for Benefits to be provided.

E. GENERAL SURGICAL SERVICES:

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

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

3. The plan also covers one surgical assistant 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 allowed for the primary surgeon.

4. Multiple or Bilateral Surgical Procedures. The value of the major procedure plus 50% of the value of the lesser procedure will be allowed 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 value of the major procedure plus 75% of the value of the lesser procedure will be allowed when multiple procedures are performed through separate incisions or in separate sites. Incidental procedures such as an appendectomy, a scar excision, a puncture of ovarian cysts, and simple lysis of adhesions, are covered under the principal amount payable. An additional Benefit is not available for those types of procedures.

F. MEDICAL SERVICES:

1. **Physician Consultations:**

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

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

   (c) There is a limit of one Physician or one Provider Visit 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 medical care from a Physician other than the surgeon for a different condition is entitled to Benefits for both the Hospital Physician care and 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, is a myelogram, or is an endoscopic procedure.

(iii) If 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 the Benefits for the 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 condition of the patient, the services provided by the additional Physician will be covered.

2. The Plan covers Inpatient care in a Hospital for a period of time that is determined to be Medically Necessary by the attending Physician after a lumpectomy, a mastectomy, or a lymph node dissection.

3. The Plan covers reconstructive breast surgery that results from a mastectomy. The Plan covers all stages of reconstructive breast surgery on the nondiseased breast to establish symmetry with the diseased breast. Benefits are available after definitive reconstructive breast surgery on the diseased breast has been performed

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

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

   Benefits for reconstructive breast surgery include, but are not limited to, prosthetic devices that are incident to a covered mastectomy and mastectomy bras. Physical complications of a mastectomy, such as lymphedemas are also covered. Outpatient chemotherapy is also covered if it follows surgical procedures.

G. PREVENTIVE AND WELLNESS SERVICES:

1. Screening and tests with a rating of A or B in the U.S. Preventive Services Task Force for prevention and chronic care. Services include, but are not limited to, counseling for the following: (i) unhealthy alcohol use; (ii) healthy diet; (iii) sexually transmitted infections; (iv) skin cancer behavior; (v) BRCA risk assessment and genetic counseling; (vi) tobacco use; and (vii) obesity. Services also include, but are not limited to, screening for the following: (i) depression; and (ii) intimate partner violence. Certain preventive medications are covered. These include, but are not limited to, aspirin, fluoride, vitamin D for adults who

are age 65 or older, folic acid for a woman who is planning or who is capable of pregnancy, iron, and tobacco cessation products. These medications must be obtained with a Prescription Order according to the guidelines that are set forth in the U.S. Preventive Services Task Force. Pre-exposure prophylaxis (PrEP) is also covered for individuals who are at high risk for HIV acquisition. Services that are directly related to the provision of PrEP are also covered under the preventive benefits. Such services include: (i) education about PrEP; (ii) a medical history; (iii) initial HIV testing to determine if PrEP is appropriate; (iv) initial lab work to determine if PrEP is appropriate; (v) a follow-up appointment for the management of side effects; (vi) subsequent lab work and discussion of the results; and (vii) prescription refills.

- If a particular PrEP is not usually covered without cost-sharing based on medical management techniques, an exception for coverage may be requested. If a health care provider recommends that a certain PrEP medication is more appropriate based on a medical determination, coverage for such medication shall be provided without cost-sharing. Refer to section VIII, G, Request For Exception For Prescription Drugs, of the Policy for the exception request process.

2. Immunizations that are for routine use in children, in adolescents, and in adults are covered. Benefits are subject to the guidelines that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. This Benefit includes influenza immunizations.

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

4. Services, tests, screening and supplies that are recommended in the U.S. Health Resources and Services Administration preventive and wellness guidelines for women are covered. Benefits include, but are not limited to, all contraceptive methods that are approved by the Food and Drug Administration ("FDA"). This includes insertion or extraction of contraceptive devices that are approved by the FDA. Benefits also include tubal ligation. A full list of the contraceptive methods can be found at: https://www.fda.gov/consumers/free-publications-women/birth-control-chart. Services that are directly related to the provision of contraceptives are also covered under the preventive benefits. Such services include: (i) office visits; (ii) counseling; (iii) medical services that are related to a sterilization procedure or the insertion of a birth control method; (iv) follow-up visits; (v) the management of side effects; (vi) counseling for continued adherence; and (vii) device removal.

   If a particular contraceptive is not usually covered without cost-sharing based on medical management techniques, an exception for coverage may be requested. If a health care provider recommends that a certain contraceptive is more appropriate based on a medical determination, coverage for such contraceptive shall be provided without cost-sharing. Refer to section VIII, G, Request For

Exception For Prescription Drugs, of the Policy for the exception request process.

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

6. Prostate cancer screening is covered when it is ordered by the Physician or the Practitioner of the Insured.

7. A colonoscopy is covered and it is subject to the following guidelines that are in accordance with the American Cancer Society:

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

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

8. A baseline mammogram for women between the ages of 35 and 39 is covered. A mammogram every two (2) years for women between the ages of 40 and 49, or more frequently if recommended by the Physician of the Insured is covered. An annual mammogram for women 50 years of age or older is covered.

H. **HOSPICE CARE:** All Services that are provided by a Hospice if: (a) the charge is Incurred by an Insured person who 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.

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

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

(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 that involve bone marrow or bone marrow components as an adjunct to high dose chemotherapy, including services related to any evaluation, treatment or therapy that involves 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. "Chemotherapy" means a dose of chemotherapy which is expected to destroy the bone marrow. "Stem Cell" means an infusion of primitive cells that are 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 chemotherapy. "Colony Stimulating Factor" means a substance which increases the reproduction, differentiation, and maturation of blood cellular components.

A period of eighteen (18) months must pass before a benefit shall be allowed for a different eligible Category II transplant.

All organs for transplants must be natural body organs. Artificial organs or any mechanical or electronic organs of any type are not eligible for Benefits. This exclusion does not apply to intra-ocular lens implants and artificial joint implants.

2. Diagnostic, medical and surgical expenses for a compatible live or cadaveric donor that are directly related to the transplant are eligible for Benefits. These expenses are only eligible if the recipient of the transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under the coverage of a recipient. This applies even if both the donor and the recipient are Insureds under this Plan. Donor charges are ineligible for Benefits if the recipient is not an Insured under this Plan.

3. The Usual and Customary amount for Implantable Hardware, as defined in the Policy, shall be limited to 300% of the invoice cost. This maximum allowable amount applies to services that are rendered at PPO and non-PPO facilities. An invoice showing the actual cost of the Implantable Hardware must be submitted to the Company.

4. Organs and body parts that are not specifically listed in this section, including but not limited to, intestines are not eligible for transplant or implant Benefits.

J. **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 services are covered

when they are authorized by a Physician and when they are required as the result of an Injury or an Illness.

K. **ANESTHESIA SERVICES:** The Plan covers anesthesia service in order to achieve general or regional (but not local) anesthesia. The service must be at the request of the attending Physician. This 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 that are provided are also covered. The services of a nurse anesthetist are covered only if they are Medically Necessary and if a Hospital employee or Physician is unavailable.

L. **MATERNITY SERVICES:**

1. Benefits for maternity are paid on a Dependent spouse or on a female Employee the same as Benefits paid on any other Illness. Maternity coverage does not include a Dependent Child of the Insured or a spouse of the Dependent Child. In no circumstances will maternity Benefits be restricted for any Hospital length of stay in connection with the childbirth for the mother or the newborn Child to less than forty-eight (48) hours after a normal vaginal delivery or to less than ninety-six (96) hours after a cesarean section. It is not necessary for a Provider to obtain authorization from the Company for a length of stay that is within these time limitations. A Hospital length of stay that is in excess of forty-eight (48) hours following a normal vaginal delivery or that is 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. Although not required, the expectant mother can call the Pre-certification company during the first trimester. This is recommended 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 are allowed if they are deemed to be Medically Necessary by the Physician due to a condition of risk to the mother or the 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 the birth.

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

   (c) All Deductibles and copayments have been paid by the Insured.

   (d) The Insured has notified the Company of the acceptability of the Insured 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 for coverage that is made available to persons pursuant to A.R.S. Title 36, Chapter 29. This does not include coverage that is 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, the attorney or the individual that is arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy. They shall also 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 the 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.

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

N. **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. The professional and the surgical services of a Physician 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 the blood and the 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 who is 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 the rental (up to the purchase price) of Durable Medical Equipment is covered. There is no allowance for the maintenance of any items that are purchased under this section.

8. Prosthetics for artificial limbs or eyes are covered. Only the initial prosthetic device is eligible for payment. This limitation does not apply if the initial device is no longer serviceable and it cannot be made serviceable.

9. Home Health Care is covered for an Insured who is homebound and who would otherwise require hospitalization. Home Health Care must be provided by a licensed home health agency. Home Health care must also be provided in the place of residence of the Insured. Home Health Care must be prescribed by the attending Physician of the Insured. Services that are provided for Home Health Care include the following.

    (a) Services that are provided by a registered nurse (RN) or by a licensed practical nurse (LPN).

    (b) Home health aide services.

    (c) Physical therapy.

    (d) Occupational therapy.

    (e) Respiratory therapy.

    (f) Speech therapy.

    (g) Medical supplies, drugs, medicines, and laboratory services, to the extent that they would have been covered if they were 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 that provides the level of care that is needed. For the purpose of air Ambulance services, the Usual and Customary amount shall be limited to 250% of the amount that is allowed by Medicare.

11. Cardiac rehabilitation therapy, such as, but not limited to, the use of common exercise equipment while under the care of a Physician 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. Therapy must be rendered within ninety (90) days after the cardiac Illness or the surgery in order to be eligible.

12. The first lens per eye that is purchased in conjunction with a cataract surgery is covered.

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 the 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. Expenses are covered for nutritional and medical assessment. Treatment consists of the services listed below.

    (a) Clinical services.
    (b) Biochemical analysis.
    (c) Medical supplies.
    (d) Prescription Drugs.
    (e) Corrective lenses for conditions that are related to the genetic inborn error of metabolism.
    (f) Nutritional management.
    (g) Special medical foods that are 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 enterally 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. Drugs and medicines that require a Prescription Order and that are prescribed for the condition(s) for which they are approved for use by the Food and Drug Administration ("FDA") are covered, unless they are otherwise excluded as set forth elsewhere in the Policy. Expenses for Prescription Drugs that are purchased through the Prescription Drug Card Plan do not apply to the medical Deductible or to the Out-of-Pocket yearly maximum. Prescription Drugs that are not purchased through the Prescription Drug card plan will be paid in accordance with the Prescription Drug card plan benefit and not as major medical benefits upon submission to the Company. 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 plan. Mail order drugs are only covered if they are purchased through the Prescription Drug Card Plan. Generic Prescription Drugs must be used whenever a Generic equivalent is available. If a brand name drug is purchased instead of a Generic equivalent, the Insured is responsible for the price difference. This Benefit includes specialty and biotech medications that are considered to be self-injectable (such as, but not limited to, Avonex, Betaseron, Enbrel, Fuzeon, Imitrex, Humira, Intron, and Rebif), even if they are administered by a Provider. Eligible Prescription Drugs that are provided for less than the standard refill amount are allowable if the Insured requests enrollment into a medication synchronization program. 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 prescribing guidelines that are clinically approved and that are regularly reviewed to ensure medical necessity and appropriateness or care. Prescription drugs that exceed the dosage that is recommended by the manufacturer or the dosage that is established by the FDA are not covered. The Company is entitled to any and all available rebates that are paid by Prescription Drug manufacturers.

Drugs and medicines that require a Prescription Order that have not been approved for use by the FDA for the specific condition for which they are being prescribed, but have been approved for use by the FDA for another condition, are eligible for Benefits if it is determined that they have been recognized as medically appropriate and effective for the treatment of the specific condition for which they are being prescribed in one or more of these 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 literature that has been reviewed by peers may also establish medical appropriateness. Medical literature must meet the requirements listed below to be acceptable.

i. At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the safety of the drug and the effectiveness for treatment of the indication for which the drug has been prescribed.
ii. No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or is ineffective or that the safety of the drug and the effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
iii. The literature meets the uniform requirements for manuscripts that are subjected to biomedical journals that are established by the international committee of medical journal editors.
iv. The literature is published in a journal specified by the United States Department of Health and Human Services as acceptable medical peer-reviewed medical literature.

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

18. Therapy for pulmonary rehabilitation is covered while under the care of a Physician. The therapy must taken place in a formal rehabilitation program at an accredited facility. The therapy must also be prescribed by a Physician. 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.

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

20. Benefits for the medically necessary treatment and management of diabetes are as follows.

    (a) Blood glucose monitors, which includes commercially available blood glucose monitors that are 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 that are designed for patient use with adaptive devices and for persons who are legally blind and who 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, which includes those that are 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 that are 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 that are 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 of each class approved by the FDA for treatment of diabetes, and a variety of drugs, when available, within each class.
    (m) Podiatric appliances for the prevention of feet complications that are associated with diabetes and that are Medically Necessary. This includes 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.
    (o) Any other device, medication, equipment or supply for which coverage is required under Medicare.

21. Diabetes self-management training and patient management is covered. Benefits include medical nutrition therapy when it is deemed Medically Necessary and when it is prescribed by an attending Physician.

22. 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 are covered. Benefits under this Plan shall not include any portion of the clinical trial that is customarily paid for by government, by biotechnical, by pharmaceutical or by 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 an 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 has been approved by an institutional review board that has an active federal-wide assurance of protection for human subjects.
d) The personnel that provide 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 not a 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 effective as any alternative that is not investigational.

23. The Plan covers amino acid-based formula that is ordered by a Physician as long as 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 a physical impairment without the use of the formula.

24. Prescription vitamins (including prenatal and pediatric vitamins), in single form or in combination form; prescription calcium supplements; and prescription hematinics are covered. Coverage is available for injectable forms and for forms that are not injectable. Benefits will be paid in accordance with the Prescription Drug Card Plan.

25. Emergency room services, supplies and treatment are covered. Benefits include psychiatric assessment and stabilization in the emergency room. Emergency care that is rendered by a non-Preferred Provider will be reimbursed as though the Insured had been treated by a Preferred Provider. This only applies if the Insured could not reasonably reach a Preferred Provider. Emergency care is that as defined in the Policy.

26. Health care services that are provided through Telehealth are covered. Benefits will only be available if the health care service would have been covered if it was rendered through an in-person consultation between the Insured and a health care provider. Benefits will be available in all areas of the state.

27. Biomarker testing is covered when used for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of an Insured's disease or condition to guide treatment decisions when the test provides clinical utility as demonstrated by medical and scientific evidence. This includes any of the following:

    (a) Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration ("FDA") or indicated tests for a drug that is approved by the FDA.
    (b) Centers for Medicare and Medicaid Services national coverage determinations or Medicare administrative contractor local coverage determinations.
    (c) Nationally recognized clinical practice guidelines and consensus statements.

    For the purposes of this provision, the following definitions apply:

    "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention. This included gene mutations or protein expressions.

    "Biomarker testing" means the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker. This includes single-analyte tests, multiplex panel tests and whole genome sequencing.

    "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

    "Consensus statements" means statements that: (i) are developed by an independent, multidisciplinary panel of experts using a transparent methodology and reporting structure that includes a conflict of interest policy; (ii) are based on the best available evidence for the purpose of optimizing clinical care outcomes; and (iii) are aimed at specific clinical circumstances.

V. GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL BENEFITS:

There are no Benefits available under this Policy for the items that are listed below.

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

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

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

4. Expenses for which payment has been made under automobile or vehicle medical payment provisions when such coverage is in force are not covered. Credit will be applied towards the Deductible and the Out-of-Pocket amounts under this Policy after such expenses have been paid by the automobile or the 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 commission of, or attempt to, commit a felony are not covered. Expenses for any loss to which the contributing cause was the Insured's being engaged in an illegal occupation are not covered.

6. Care or treatment of an Accident, an Illness or an Injury that is caused by, or arising out of the following: riot; war; an act of war while in the military, the naval, or the air services of any country at war, including but not limited to, declared or undeclared war; or acts of aggression committed by a person who is 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 an Illness or an Injury is involved.

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

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

10. Expenses for the care, the treatment or operations which are performed primarily for Cosmetic purposes are not covered. Complications of such procedures are not covered. This exclusion does not apply when expenses are incurred as a result of an Injury. This exclusion also does not apply when expenses are incurred for reconstructive surgery that follows a mastectomy. This exclusion also not apply when expenses are for the repair of a congenital anomaly.

11. Expenses for the 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 that are for the purpose of weight loss or weight control. This exclusion does not include screenings and counseling that are allowed under preventive and wellness services, which are covered as stated elsewhere in the Plan.

12. Expenses in connection with a reversal of a gastric or an intestinal bypass; a balloon implant; a gastric stapling; or other similar surgical procedure are not covered.

13. Expenses for treatment or services that are rendered in connection with invitro fertilization or with artificial insemination are not covered.

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 that are not classified as Mental Illness as defined in the policy are not covered. 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 that are in excess of the Usual and Customary amount that is accepted as payment for the same service within a geographic area are not covered.

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. This exclusion includes drugs for the same.

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

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 the 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 for the easing of chronic intractable pain by a pain control center or in a pain control program are not covered. This exclusion applies if 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 a 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 they were not provided in this type of facility will be considered for Benefits on an outpatient basis, and are subject to all other Policy provisions. These expenses must be billed separately from the facility charges.

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

28. Expenses for 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 nursing home are not covered.

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

30. Expenses for an Illness or an Injury resulting from the Insured's use or abuse of any illegal drug are not covered.

31. Expenses are not covered 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 that result directly or indirectly, in whole or in part, from the Insured's abuse of Prescription Drugs that are 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 are not covered for any services or products unless the services or products are both of the following.

(a) The services or products are Medically Necessary.

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

35. Expenses for training, for educating, or for counseling a patient are not covered. This exclusion does not apply when such services are provided, 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 an Illness or an Injury.

38. Expenses for transportation are not covered. This exclusion does not apply to ambulance services that are Medically Necessary. 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 by ambulance.

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

(c) Ambulance services that do not go to the nearest facility that is expected to have the appropriate services for the treatment of the Injury or the Illness that is 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 an Illness or an 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 preventive medical care are not covered (except as specifically set forth in the Schedule of Benefits).

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

43. Expenses for telephone consultations are not covered unless they are provided in accordance with the provisions for telemedicine as covered elsewhere in the Policy.

This exclusion applies whether the expenses are initiated by the Insured or by the Provider.

44. Expenses are not covered for the care and treatment of: teeth; gums; or alveolar process; dentures; dental appliances; or supplies that are 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 the dental coverage has been selected and the premiums have been paid.

45. Expenses for services that are incurred for the drainage of an intraoral alveolar abscess are not covered.

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

    If surgical treatment is deemed to be Medically Necessary and is in accordance with accepted medical practice as that is determined by the Company, Benefits will be allowed at **50%** as long as 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 that are incurred with respect to the eye for diagnostic procedures are not covered. This exclusion, includes, but is 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 premiums have been paid. This exclusion does not apply to lens implants (either donor or artificial) for cataracts. This exclusion also does not apply when services are required as part of an examination to diagnose an Illness or an 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; to orthokeratology; to corneal carving; and to corneal slicing.

49. Expenses for hearing examinations; hearing aids; or the fitting of hearing aids; cochlear implants; or any devices that are 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 an 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 is not covered. 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 are not covered. 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); of corns; or of calluses. Removal of the nail matrix or root is covered when it is prescribed by a Physician for a metabolic or peripheral vascular disease.

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 acupuncture or for acupressure are not covered.

53. Expenses for radioallergosorbent ("RAST") testing are not covered.

54. Expenses for preventative medication (except as set forth elsewhere in the Plan); for vitamins without a prescription; for mineral and nutrient supplements; for fluoride supplements; for food supplements; for sports therapy equipment, and for the services and the applications of such are not covered.

55. Expenses for anabolic steroids; for weight-reduction drugs; for growth hormones; and for hematinics without a prescription are not covered.

56. Expenses for services, supplies, and treatment that are for hair loss are not covered. This exclusion includes, but is not limited to, the use of minoxidil and Rogaine.

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

58. Expenses for autopsy procedures are not covered.

59. Expenses for treatment or services that are rendered 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 that are designed to help or treat infertility.

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

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

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

63. Expenses for massage therapy are not covered.

64. 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.

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

66. Expenses that are incurred as the result of the Insured committing a fraudulent insurance act are not covered.

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

68. Drugs and medicines that are available over the counter are not covered (except as covered elsewhere in the preventive and wellness section of the Policy). Drugs and medicines that do not require a Prescription Drug Order are not covered.

69. Expenses that result from clearly identifiable and preventable medical errors that result in death, loss of a body part, or a serious disability are not covered. 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 bedsores that are acquired in the Hospital.

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

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

COBRA coverage is available if any of the following qualifying events occurs.

1. A termination of employment.
2. A reduction of hours.
3. The death of the Employee.
4. The Employee become entitled to Medicare benefits.
5. A divorce or legal separation.
6. The Dependent child ceases to be a dependent under the plan.

In the case of a divorce, a 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. The Employee must also send a copy of the notice to the Company. Election of the continuation coverage must be in writing and must be done within 60 days after the Employer sends a notice of the right to elect the continuation coverage. If the 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 the termination has the right to select the COBRA coverage independently. A newborn Child or a Child that is placed for adoption during a period of COBRA continuation coverage is also eligible for coverage for the remaining period of the continuation coverage. This only applies if a newborn Child or a Child that is placed for adoption is enrolled according to the terms of the Policy. The continuation of coverage that is provided by the vision and the 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 the Dependent Child(ren) if the 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 the group health coverage terminates due to the employee's termination of employment or a reduction in hours. There are three exceptions as described below.

1. The continuation period for all qualified beneficiaries may become 29 months from the date of the termination of employment or a reduction in hours. This continuation period only applies if an Employee or Dependent is disabled (as determined by the Social Security Administration) at any time during the first 60 days after one of those qualifying events. For the 29-month continuation period to apply, written notice of the disability determination must be provided to the Employer. This written notice must be provided within both the 18-month coverage period and within 60 days after the date of the determination.
2. The continuation period for a Spouse and/or Dependent Child(ren) may become 36 months from the date of the initial termination of employment or reduction in hours. This continuation period only applies if a second qualifying event that gives rise to a 36-month period for the Spouse and/or Dependent Child(ren) (for example, the Employee dies or becomes divorced) occurs within the 18-month or 29-month continuation coverage period. For the 36-month continuation period to apply, written notice of the second qualifying event must be provided to the Employer. This notice must be provided 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 the 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 of the 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 the continuation coverage. All of the subsequent premiums are due on the first day of the month and are subject to a 31-day grace period.

Continuation coverage will automatically terminate if any of the events listed below occurs.

1. The employer no longer provides group health coverage for any employees.
2. The premium for the 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 COBRA coverage period expires.

B. **The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"):** 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 if the Employee is absent from employment due to service in the uniformed services. Election of the continuation coverage must be made in writing within sixty (60) days of the date that commences with any leave for military service.

Continuation coverage will automatically terminate if the Employee fails to pay the required premium. Coverage will also automatically terminate if the Employee loses his rights under USERRA as a result of undesirable conduct. Undesirable conduct includes being court martialed and being dishonorably discharged.

The Insured Employee and his Dependents will be entitled to the protections of both COBRA and USERRA when coverage is lost under the group health Plan because the Employee leaves work to perform military service, and the group health Plan is subject to COBRA. When the requirements of COBRA and USERRA differ, the Employee and his 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 Periods of Disability**:

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

Disability related expenses: In the event that the group Policy terminates for any reason while Benefits are being paid and it is established that the Insured was totally Disabled when such insurance terminated, Benefits for expenses that are incurred in connection with the Injury or the Illness that caused the Disability will be continued. Benefits will continue during such Total Disability until the earliest of the events listed below.

5. Twelve (12) months from the date on which the insurance terminated.

6. The Employee or the Dependent(s) ceases to be Totally Disabled.

7. The Disabled person becomes insured or covered under any other group medical benefit or a service plan or a self-funded plan.

D. **Conversion Plan:** All individuals who were covered under the group Policy have the right to continue coverage under a conversion plan of the Company when the group coverage terminates. The conversion plan will be a group insurance plan which provides coverage most similar to that of the terminated coverage. The right to conversion is available under the following circumstances.

1. Upon the termination of the employment of the Employee.

2. Upon the death of the Employee. This provision applies to the surviving Spouse and, at the option of the Spouse, the Child(ren) for whom the Spouse has responsibility for care and support.

3. Upon the divorce, the annulment, or the legal separation of the Employee and the Spouse. This provision applies to the surviving Spouse and, at the option of the Spouse, the Child(ren) for whom the Spouse has responsibility for care and support.

4. Upon a Dependent Child ceasing to be a qualified Dependent. This provision applies to the Child.

An individual does not have conversion rights, and the conversion plan will terminate, if any of the following apply.

1. The individual has failed to pay premiums or premiums are not received in a timely manner.

2. The individual is eligible for Medicare or acquires other group health coverage that is comparable to the coverage under the conversion plan;

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

Written application and the first premium payment for the converted policy shall be made to the Company within thirty-one (31) days following the termination of

coverage under the existing policy. The effective date of the conversion plan is the day following the termination of the insurance under the group Policy.

E. **Extension of Benefits:**

1. If the Employer employs fewer than 20 Employees, an Employee and any qualified Dependent whose insurance under the group Policy has been terminated may elect to continue coverage under the group Policy, provided the Employee has been covered under the Employer's health benefit plan for at least three (3) months before a qualifying event. This provision does not apply if continuation coverage benefits are available to Insureds pursuant to 29 United States Code sections 1161 through 1169, or 42 United States Code sections 300bb-1 through 300bb-8, or if the Insured seeking to continue coverage is eligible for Medicare.

   For purposes of this section, qualifying event means:

   (a) Voluntary or involuntary termination of employment for a reason other than gross misconduct or reduction of hours required to qualify for health benefits under the Employer's health benefit plan.
   (b) Divorce or legal separation from the Employee.
   (c) Death of the Employee.
   (d) The Employee becoming eligible for Medicare.
   (e) A Dependent Child ceasing to be eligible for coverage under the terms of the Policy.

   The Employer shall provide the Insured written notification of the Insured's qualifying event and of the right to continue group coverage within thirty (30) days after the qualifying event. A written communication or a notice postmarked within forty-four (44) days after a qualifying event mailed by the Employer to the Insured's last known address satisfies this notice requirement. Notice to the Employee constitutes notice to any qualified Dependent unless the Employer knows there is a qualified dependent who does not live at the same address and knows the Dependent's address, in which case, a separate notice shall be sent to the qualified Dependent. The notice shall inform the Insured of the following:

   (a) The Insured's right to continue coverage at the full cost of the coverage, which includes the Employer's contribution and the Insured's contribution and an administrative fee for the Employer that may not exceed five (5) percent of the premium.
   (b) The amount of the full cost of coverage, stated separately for the Employee and qualified Dependent.
   (c) The process and deadline for the Insured to elect continuation coverage.
   (d) The date and time by which the Insured must submit the initial and ongoing payments to the Employer to continue coverage.
   (e) The loss of continuation coverage if the Insured fails to pay the premium and administrative fee in a timely manner.

   To continue coverage, the Insured shall elect continuation coverage in writing within sixty (60) days after the date of notice to elect continuation coverage, and

submit the first month premium to the Employer within forty-five (45) days after the date of election to continue coverage. If the Insured elects coverage, coverage continues as if there had been no interruption. If the Employer fails to provide complete, accurate and timely notice of the right to continue coverage, the Insured has one hundred twenty (120) days after the date of the notice to elect continuation coverage and pay the required premium and administrative fee.

2. Continuation of coverage ends on the earliest of the following:

   (a) Eighteen (18) months after the date the continuation coverage begins.
   (b) The date on which coverage ceases under the Policy due to the Insured's failure to timely pay the premium and administrative fee.
   (c) The date on which the Insured becomes eligible for Medicare or Medicaid or obtains any other health care coverage, with respect only to that person.
   (d) The date on which the Employer terminates coverage under the group health insurance for all Employees.
   (e) As to a Dependent Child, the date the Dependent Child would otherwise lose coverage under the terms of the health plan due to attaining a certain age.

3. A qualified Dependent who is determined to have a disability under title II or title XVI of the social security act at the time of a qualifying event may be eligible to continue coverage for an additional eleven (11) months, if the qualified Dependent provides the written determination of disability from the social security administration to the Employer within sixty (60) days after the date of determination and before the end of the eighteen (18) month continuation period. The Plan may charge up to one hundred fifty (150) percent of the group rate during the eleven (11) month disability extension. The qualified Dependent shall notify the Employer within thirty (30) days after the social security administration determines that the qualified Dependent no longer has a disability under title II or title XVI of the social security act.

4. If a qualified event as defined in this section occurs during the eighteen (18) month continuation period, a qualified Dependent may be eligible to continue coverage for an additional eighteen (18) months.

5. If an Employee is in the military reserve or national guard and is called to active duty and the Employee's employment is terminated either after or during the active duty period, the termination is a separate qualifying event, distinct from the qualifying event that may have occurred when the Employee was called to active duty, and the Employee and any qualified Dependents are eligible for a new eighteen (18) month benefit period beginning on the later of the date active duty ends or the date of employment termination.

6. If an Employee is in the military reserve or national guard and is called to active duty, the following event are qualifying events distinct from the qualifying event that may have occurred when the Employee was called to active duty.

   (a) The Employee dies during the period of active duty.

(b) A divorce or legal separation of the Employee from the Employee's Spouse occurs.
(c) A Dependent Child ceases to be a Dependent Child to be eligible for coverage under the terms of the Policy.

7. Notwithstanding section 2 above, if an Employee who is in the military reserve or national guard has elected to continue coverage and is thereafter called to active duty and the coverage of the Employer's health benefit plan is terminated due to the Employee becoming eligible for a health care program provided by the United States department of defense, the eighteen (18) month period or any other applicable maximum time period for which the Employee would otherwise be entitled to continuation coverage is tolled during the time that the Employee is covered under the health care program. Within sixty-three (63) days after the federal health care program coverage terminates, the Employee may elect to continue coverage under the Employer's health benefit plan retroactively to the date coverage terminated under the federal health care program for the remainder of the eighteen (18) month period or any other applicable time period, subject to termination of coverage at the earliest of the conditions specified in section 2 above.

VII. 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 any of the following.

   (a) Group insurance or group-type coverage, whether insured or uninsured, prepaid plans, 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 that is 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. The Benefits under this Plan 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 that establish 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 shall be determined before the benefits of a health care coverage which covers such a person as a Dependent.

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.

   NOTE: If the other health care plan does not have a coordination of benefits rule based on the parents' birthdays, 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 where 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).

   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. This does not apply with respect to any claim determination period or year during which benefits are actually paid or 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 expenses of the Child, the order of benefit determination rules outlined in Section VII, A(2)(c)(2) shall apply.

4. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.
5. The benefits of a plan that covers a person as an Employee (or as that Employee's Dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that person's Dependent). 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 pays in the following situations.

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

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

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

3. This Plan will pay its Benefits only after Medicare has paid its benefits in the following situations.

   (a) For all other Insured persons.

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

VIII. GENERAL POLICY INFORMATION:

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

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

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

The Company reserves the right to change the rate for any insurance that is 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 to the classes of persons Insured.

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

B. **PAYMENT OF PREMIUMS:** All premiums that are due under this Plan, and any adjustments, are payable by the Policyholder on or before their respective due dates. 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 the 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, including a pro rata premium for the grace period. If the Policyholder gives written notice to the Company that this Plan is to be terminated before the end of the grace period, this Plan shall be terminated on the later of the date of receipt of such notice, or the date specified by the Policyholder. The Policyholder shall be liable to the Company for the payment of all premiums that are then due and are unpaid. That amount shall include a pro rata premium for the period that commences with the last premium due date and that ends 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, and the beneficiary who is designated by each Employee, if any. This record shall also show the date when each Employee became Insured and the Effective Date of any change in coverage. This record shall also show any other information that may be required to administer the insurance. The Company shall furnish a copy of this record to the Policyholder, upon request. The Policyholder shall give the Company any information that is required to administer the insurance. This information shall include, but is not limited to, information for enrolling Employees, changes in coverage, and termination of insurance. Any records of the Employer and/or the Policyholder that may have a bearing on this insurance shall be open for inspection by the Company at a reasonable time.

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

G. **CLAIM AND APPEAL PROCEDURES:** Following is a description of how the Plan processes claims and appeals. 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. At the time coverage is renewed, we will also send a separate statement explaining that another copy of the packet may be requested. The packet will also be sent within five (5) business days after we receive a request for an appeal. We will also send a copy of the packet to you or your treating provider at any time upon request. Another copy may be requested by calling the Company at (801) 263-8000 or (800) 748-5340.

A claim is defined as any request for a Plan Benefit that is made by an Insured or a representative of an Insured, and 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 and for request for further information or denial. Each type of claim also has a specific time period for appeal reviews. Time periods begin at the time that a claim is received. "Days" refers to calendar days, unless stated otherwise.

Pre-Service Claim

A "pre-service claim" is any claim for which Pre-certification is required to obtain medical care in order to receive Benefits. The Insured will receive a notification of the benefit determination for a pre-service claim within fifteen (15) days after the receipt of the request. If additional information is needed, the Insured will be notified within that time. The Insured will be given at least forty-five (45) days to respond. A notification of the benefit determination will be sent within fifteen (15) days after the receipt of the additional information. 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 a termination of the concurrent care benefit that was previously before the end of the treatment period, a notification will be sent at least fifteen (15) days prior to the end of the treatment.

Pre-certification for pre-service claims that involve Urgent Care is **not** required, although it is recommended. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. The pre-service claim will be subject to the time periods that are described above.

Post-Service Claim

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

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. The Insured will be given at least forty-five (45) days to respond. A notification of the benefit determination will be sent within fifteen (15) days after the receipt of the additional information.

Notice to Insured of Adverse Benefit Determination

Adverse benefit determination means a denial of, a reduction of, a termination of, or a failure to provide or make payment for, in whole or in part, a Benefit. Adverse benefit determination includes 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 an electronic notification that sets forth the reason for the adverse benefit determination.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. If you decide to appeal the decision to deny a pre-service claim, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of a patient's condition.

	Expedited Appeals	**Standard Appeals**
	(for urgently needed services you have not yet received)	(for non-urgent services or denied claims)
Level 1.	Expedited Medical Review	Informal Reconsideration
Level 2.	Expedited Appeal	Formal Appeal
Level 3.	Expedited External Independent Review Medical Review	External Independent Medical

MedWatch makes the Level 1 and the Level 2 decisions for expedited appeals. WMI makes the Level 1 and Level 2 decisions for standard appeals, unless 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. In that case, we will consult with an independent health care professional who has the appropriate training and the expertise in the field of medicine that is involved in the medical judgment. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

EXPEDITED APPEALS PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1. Expedited Medical Review

Your request: You may obtain an expedited medical review of your denied pre-service claim for urgently needed services if all of the following apply.

- You have coverage with us.
- We denied your pre-service claim for urgently needed services.
- Your treating provider certifies in writing and provides supporting documentation that the time to process your request through the Informal

Reconsideration and Formal Appeal process (about 30 days) is likely to cause a significant negative change in your medical condition. Your treating provider must send the certification and supporting documentation to:

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

Our decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and pre-certify your requested service. Within that same business day, we must call and tell you and your treating provider our decision, and mail you our decision in writing. The written decision must explain the reasons for our decision and identify the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2.

If we grant your request: We will pre-certify the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Expedited Appeal

Your request: If we deny your request at Level 1, you may request an expedited appeal. After you receive the Level 1 denial, your treating provider must immediately send a written request to the same entity and address that was used for the Level 1 appeal to tell us you are appealing to Level 2. To help your appeal, your provider should also send any additional information that hasn't already been sent, to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3. If you decide not to appeal to Level 3 you have the right to file suit in court.

If we grant your request: We will pre-certify the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You only have 5 business days after you receive the Level 2 decision to send your written request for expedited external independent review.

Send your request and any additional supporting information to the same entity that was used for the Levels 1 and 2 appeals.

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals depending on the issues in your case.

(1) Medical Necessity

These are cases where we have decided not to pre-certify a service because we think the services that you or your treating provider are asking for are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), procured by the Arizona Department of Insurance and Financial Institutions, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where we have denied coverage because we believe that the requested service is not a covered benefit under your insurance policy. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must do the following.

1. Mail a written acknowledgement of the request to the Director of the Department of Insurance and Financial Institutions ("Director"), you, and your treating provider.

2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving our information, the Director must send all of the submitted information to an external IRO.

Within 72 hours of receiving the information the IRO must make a decision and send the decision to the Director.

Within 1 business day of receiving the IRO's decision, the Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should pre-certify the service, we must do so. If the IRO agrees with our decision to deny the pre-certification, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, we must do the following.

1. Mail a written acknowledgement of the request to the Director, you, and your treating provider.

2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Director must determine if the service is covered, issue a decision, and send a notice to us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Informal Reconsideration

Your request: You may request an Informal Reconsideration if you receive a denial on your pre-or post-service claim if all of the following apply.

- You have coverage with us,

- We denied your pre-service claim or your post-service claim,

- You do not qualify for an expedited appeal, and

- You or your treating provider asks for an Informal Reconsideration within 2 years of the date we first deny the pre-service claim or the post-service claim by calling or sending your request to:

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

Our acknowledgment: We have 5 business days after we receive your request for an Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that your request was received.

Our decision: For a denied pre-service claim, we have 15 calendar days after the receipt date to decide whether we should change our decision and pre-certify your requested service. For denied post-service claims, we have 30 calendar days to decide whether we should change our decision. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and must identify the documents on which we based our decision.

If we deny your Level 1 review: You have 60 calendar days to appeal to Level 2.

If we grant your appeal: We will pre-certify the service or pay the claim and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Formal Appeal

Your request: You may request a Formal Appeal if you receive a denial on your Level 1 review. After you receive the Level 1 denial, you or your treating provider must send us a written request within 60 days to advise us that you are appealing to Level 2. To help us make a decision on your appeal, you or your provider should also send us any additional information that you haven't already sent us, to show why we should pre-certify the requested service or pay the claim. Send your appeal request and information to the same entity and address that was used for the Level 1 appeal to tell us you are appealing to Level 2.

Our acknowledgment: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that your request was received.

Our decision: For a denied pre-service claim, we have 15 calendar days after the receipt date to decide whether we should change our decision and pre-certify your

requested service. For a denied post-service claim, we have 30 calendar days to decide whether we should change our decision. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and identify the documents on which we based our decision.

If we deny your Level 2 appeal: You have four months to appeal to Level 3. If you decide not to appeal to Level 3 you have the right to file suit in court.

If we grant your appeal: We will pre-certify the service or pay the claim and the appeal is over.

Level 3: External, Independent Review

(Note: Level 3 appeals cannot be accepted for issues regarding deductible amounts, co-insurance levels, or usual and customary allowed amounts)

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have four months after you receive our Level 2 decision to send us your written request for external, independent review. Send your request and any additional supporting information to the same entity and address that was used for the Level 1 and Level 2 appeals.

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical Necessity

These are cases where we have decided not to pre-certify a service or we have denied a claim because we think the services that you or your treating provider are asking for, or the services that you have already received, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), procured by the Arizona Department of Insurance and Financial Institutions, and not connected with our company. For medical necessity cases, the provider must be a provider who typically manages the condition under review.

(2) Contract Coverage

These are cases where we have denied coverage because we believe that the requested service or the service already provided is not a covered benefit under your insurance policy. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must do the following.

1. Mail a written acknowledgement of the request to the Insurance Director, you, and your treating provider.

2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 days of receiving our information, the Director must send all of the submitted information to an IRO.

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Director.

Within 5 business days of receiving the IRO's decision, the Director must mail a notice of the decision to us, you, and your treating provider.

The decision: If the IRO decides that we should pre-certify the service or pay the claim, we must do so. If the IRO agrees with our decision to deny the pre-certification or claim, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must do the following.

1. Mail a written acknowledgement of the request to the Director you, and your treating provider.

2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Director must determine if the pre-service or post-service claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Referral to the IRO for contract coverage cases: The Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider

The decision: If you disagree with the Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Insurance Director's final decision on a coverage issue, we may also request a hearing with OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of the records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time that the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

The Role of the Department of Insurance and Financial Institutions

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, for decisions that can be appealed, you must pursue the health care appeals process before the Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to do the following.

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan that is submitted by insurers.
3. Receive, process and act on requests from an insurer for external, independent review.
4. Enforce the decisions of insurers.

5. Review the decisions of insurers.
6. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings ("OAH").
7. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

Binding Nature of the External Review Decision: If the Insured's plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the IRO will be final and binding on the Company. The Insured may have additional review rights provided under federal ERISA laws.

REQUEST FOR EXCEPTION FOR PRESCRIPTION DRUGS

Notwithstanding the procedures outlined in the above sections regarding appeals, the following procedures are available for an Insured, the Insured's designee, or the Insured's Physician (or other prescriber) to request and gain access to clinically appropriate drugs that are not otherwise covered by the Plan.

Standard review exception request: A request for a standard review must be submitted in writing to the Company and must set forth the reason that the requested drug is appropriate for the care of the Insured. A determination on the standard review request will be made, and notification will be sent to the Insured or the Insured's designee, and to the prescribing Physician (or other prescriber), no later than 72 hours following receipt of the request. If the standard exception request is granted, coverage will be provided for the duration of the prescription, including refills.

Expedited review exception request: A request for an expedited review based on exigent circumstances may be submitted orally or in writing to the Company. Exigent circumstances exist when an Insured is suffering from a health condition that may seriously jeopardize the Insured's life, health, or ability to regain maximum function, or when an Insured is undergoing a current course of treatment using a non-formulary drug. A determination on the expedited review request will be made, and notification will be sent to the Insured or the Insured's designee, and to the prescribing Physician (or other prescriber), no later than 24 hours following receipt of the request. If the expedited exception request is granted, coverage will be provided for the duration of the exigency.

External review exception request: If the Plan denies a standard review request or an expedited review request, the Insured, the Insured's designee, or the Insured's Physician (or other prescriber) may request that the original exception request and

the subsequent denial of such request be reviewed by an independent review organization. A determination on the request will be made, and notification will be sent to the Insured or the Insured's designee, and to the prescribing Physician (or other prescriber), no later than 72 hours following receipt of the request, if the original request was a standard review request, and no later than 24 hours following receipt of the request, if the original request was an expedited review request. If the external review request of a standard review request is granted, coverage will be provided for the duration of the prescription. If the external review request of an expedited review request is granted, coverage will be provided for the duration of the exigency.

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 such 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 the earnings that are required to maintain minimum compulsory surplus required by law. Earnings is defined as earned revenue that is in excess of incurred Benefits and expenses using statutory accounting methods that are prescribed or that are permitted by law.

In any Calendar Year in which there are surplus earnings as a result of favorable claims experience such earnings may be refunded to eligible participating Employers as an experience rating refund. The board of directors will determine in its discretion if it is appropriate and if it is advisable to return the surplus earning to the Policyholders. The method and the timing of the refund is determined by the board of directors of the Company. To be eligible to participate in the refund, a participating 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 for Benefits, Benefits may be reduced in accordance with an equitable plan approved by law.

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

L. **ENTIRE CONTRACT:** This Plan and all attachments hereto, including the applications of the Policyholder, and the Insured Employees constitute the entire contract between the parties. All statements that are made by the Policyholder or by the Insured Employees and Dependents shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Employee or his/her Dependent shall affect the insurance or be used in defense to a claim hereunder unless such statement is formalized in writing and a copy of such statement is 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. The Plan may also be amended on the renewal date of the Plan upon sixty (60) days written notice from the Company to the Policyholder. If an Insured is confined in a Hospital or in 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 waive any provision thereof.

N. **NOTICE AND PROOF OF CLAIM:** A written or an 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 that is 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 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.

O. **EXAMINATION:** The Company shall have the right and opportunity to have the person of any individual whose Injury or Illness is the basis of a claim examined when and so often as it may reasonably require during pendancy of a claim. 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:** Benefits that are provided in the Plan will be paid promptly after receipt of due proof. All Benefits are payable to the Employee or to his legal assignee. If any such Benefits remain unpaid at the death of the Employee, if the Employee is a minor, or if the Employee is, in the opinion of the Company, legally incapable of giving a valid receipt and discharge for any payment, the Company may, at its option, pay such Benefit to the Employee's legal heirs. Any payments made will constitute a complete discharge of the obligations of the Company to the extent of such payment. The Company will not be required to see the application of the money so paid.

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

R. **OVERPAYMENTS:** If for any reason the Company pays any amount to or on behalf of the Insured for (i) services that are not covered under this Plan; (ii) services which exceed the amounts to be paid as Benefits under this Plan; or (iii) 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 rendered to the same Insured.

S. **LEGAL PROCEEDINGS:** No action of law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan. No such action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

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

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

The 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.

V. **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.

W. **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.

No Surprises Act Provisions

If an Insured receives Emergency services at a non-PPO facility or receives Emergency services at a PPO facility but by a non-PPO Provider within such facility, the cost sharing amount for the Insured will be determined from the recognized amount as defined in the federal No Surprises Act and will be processed at the PPO cost sharing level. If an Insured receives Eligible Charges for air Ambulance services from a non-PPO provider the cost sharing amount for the Insured will be determined from the qualified payment amount as defined in the federal No Surprises Act or the lesser of billed charges and will be processed at the PPO cost sharing level. The Insured will only be responsible for the PPO cost sharing amounts. The Provider may not balance bill the Insured for any amounts above the PPO cost sharing level.

The above provision also applies if an Insured receives non-Emergency services at a PPO facility but by a non-PPO Provider within such facility. However, if an Insured receives a notice from the Provider prior to services being rendered that states that the Provider is a non-PPO Provider and that contains a good faith estimate of the amount that will be charged, and the Insured voluntarily agrees to receive such care, the Benefit protections set forth above will be waived. Notwithstanding this provision, such protections cannot be waived if there is no PPO provider available, for Urgent Care, or for services rendered by certain types of Providers as determined by federal law.

For the purposes of this provision, Emergency services means a medical screening examination that is within the capabilities of the emergency department of a Hospital or of an independent freestanding emergency department, including ancillary services that are routinely available to the emergency department to evaluate such Emergency medical condition, and further medical examination and treatment to stabilize the patient that is within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department.

Emergency services also includes items and services that are furnished by a non-PPO Provider or non-PPO Emergency facility (regardless of the department of the Hospital in which such items and services are furnished) after the patient is stabilized and as part of outpatient observation or an Inpatient or outpatient stay with respect to the visit in which the items and services are furnished. This does not apply if: (1) the Provider or facility determines that the patient is able to travel using nonmedical transportation or nonemergency transportation; (2) the Provider furnishing such additional items and services satisfies the notice and consent criteria with respect to such items and services; and (3) the patient is in a condition to receive and to provide informed consent.

Continuity of Care

If an Insured is a continuing care patient who is receiving treatment from a Preferred Provider and such Provider experiences a change in PPO status due to: (1) the Provider's contract being terminated during the course of the treatment for a reason other than for fraud or for failure to meet quality standards; (2) the Provider's contract being terminated due to a change in the terms of participation of the

contract; or (3) the Policyholder's contract with the Company is terminated resulting in a loss of benefits, the Insured may continue to obtain treatment from such Provider if the Insured: (1) is undergoing a course of treatment for an acute Illness that requires specialized treatment to avoid the reasonable possibility of death or permanent harm; (2) is undergoing treatment for a chronic Illness which is life-threatening, degenerative, potentially disabling, or congenital, and which requires specialized medical care over a prolonged period of time; (3) is undergoing a course of institutional treatment or Inpatient care from the Provider; (4) is scheduled to undergo non-elective surgery from the Provider, including receipt of postoperative care from such Provider with respect to such surgery; (5) is pregnant and undergoing treatment for pregnancy from the Provider; or (6) is terminally ill and receiving treatment for such illness from the Provider. Benefits for such treatment will be processed at the PPO cost sharing level.

The Plan will: (1) notify each continuing care patient on a timely basis of such Provider termination and of the individual's right to elect continued transitional care from the Provider; (2) provide such individual with an opportunity to notify the Plan of the individual's need for transitional care; and (3) permit the individual to elect to continue to have Benefits provided under such Plan, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered had such termination not occurred. Such coverage must be provided during the period beginning on the date on which the notice is provided and ending on the earlier of: (1) 90 days from such notice; or (2) the date the Insured no longer requires such continuing care.

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

Y. **QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO"):** A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law. A QMSCO 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.

IX. 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 that are received from health care providers.

- **Disclosure of Information.** We may disclose your personal information to agents, to health care providers, or to 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. You may also file a written complaint 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. The complaint must be filed within 180 days of the known date of violation. You will not be retaliated against for filing a complaint.