WESTERN MUTUAL INSURANCE COMPANY

Patient Protection and Affordability Care Act ("PPACA") Amendment

The provisions below are required by federal health care reform. These provisions are effective on January 1, 2011. These provisions replace any language in the Certificate to the contrary. Changes or clarifications will be made on a continuing basis in order to comply with federal or state regulations, guidance, or interpretations as they are developed. Benefits that are mandated by state law that are more generous than those required by federal health care reform will continue in force at the current benefit level.

Dependent Age

The limiting age for a non-disabled dependent child is until attainment of twenty-six (26) years. This applies regardless of financial dependency, residency with the parent or with any other person, student status, employment, or any combination of those factors. Eligibility for coverage does not include the spouse or child of such dependent child.

Lifetime Limit

The maximum lifetime benefit (per Insured) of $2,000,000 is removed. Any other benefit-specific lifetime dollar limit referenced in the Policy pertains only to those health care services and supplies that are not "Essential Benefits" as defined and interpreted in PPACA.

Annual Limit

This policy has a maximum annual benefit (per Insured) of $2,000,000. This maximum is applicable to the "Essential Benefits" listed below, as they are defined and interpreted in PPACA, provided the services are otherwise eligible according to the terms of the Policy. Any other benefit-specific annual dollar limit referenced in the Policy pertains only to those health care services and supplies that are not "Essential Benefits" as defined in PPACA. The definition of "essential benefits" is subject to periodic change by the U.S. Department of Health and Human Services.

1) Ambulatory patient services.
2) Emergency services.
3) Hospitalization.
4) Maternity and newborn care.
5) Mental health and substance abuse, including behavioral health treatment.
6) Prescription drugs.
7) Rehabilitative and habilitative services and devices.
8) Laboratory services.
9) Preventive and wellness services and chronic disease management.
10) Pediatric services, including oral and vision care.

Preexisting Condition

The preexisting condition exclusion is not applicable for children up to, and including, the age of eighteen (18).

Recission

Coverage may be rescinded if an Insured performs an act, practice, or omission that constitutes fraud or if an Insured makes an intentional misrepresentation of a material fact. At least thirty (30) days advance written notice will be provided to the Insured prior to the rescission of coverage.

Preventive Care

If the following services are provided by a **PPO provider**, benefits are not subject to the Deductible, and benefits are paid with no cost-sharing by the Insured. If the following services are provided by a **non-PPO provider**, benefits are subject to the regular Deductible and regular cost-sharing provisions of the plan, and other applicable plan provisions. Additional information is available on the website of the U.S. Department of Health and Human Services at www.healthcare.gov, or by contacting WMI Mutual Insurance Company at 1-800-748-5340 or 801-263-8000.

1) Evidence-based services with a rating of A or B in the US Preventive Services Task Force.
2) Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control.
3) Evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the guidelines of the Health Resources and Services Administration.
4) Additional preventive care and screenings for women provided in the guidelines of the Health Resources and Services Administration.
5) Recommendations issued by the US Preventive Services Task Force for women regarding breast cancer screening, mammography, and prevention.

Emergency Services

Eligible emergency services that are performed in an emergency department of a hospital are not subject to precertification requirements, and are paid at the PPO coinsurance level regardless of the status of the provider. The Insured is responsible for any amount billed by a non-PPO provider over the allowable amount, and for any ineligible amounts.

Internal Claims and Appeals and External Review

1) Benefit determinations in the case of claims involving Urgent care will be made within 24 hours of the receipt of the claim, unless the Insured fails to provide sufficient information to make the determination.
2) The Insured may review the claim file and present evidence and testimony as part of the internal claims and appeal process. If the Plan: (a) considers, relies upon, or generates any new evidence in connection with a claim, or (b) bases an appeal decision on any new or additional rationale, the evidence or rationale will be provided to the Insured, free of charge, sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the Insured a reasonable opportunity to respond prior to that date.
3) A third, voluntary external review level is available once the internal appeals process is exhausted. Exhaustion of the internal appeals process is not necessary if the Plan has waived this requirement in writing, or if the Plan has failed to comply with any of the requirements of the internal appeals process. The external review level is only available for adverse benefit determinations involving medical necessity or appropriateness of care, or experimental/investigational services. An Insured must submit a request for an external review within four (4) months from the date of the final adverse benefit determination. The external review will be reviewed by an independent review organization ("IRO") that is assigned by the state. The IRO will provide written notice of its decision for a standard review within no more than forty-five (45) days after receipt of the request for review. The IRO will provide written notice of its decision for an expedited review within no more than seventy-two (72) hours after receipt of the request for review. The Company will accept and comply with the findings made by the IRO and will pay for the reasonable costs of the independent review.
4) There are two options for external review: (a) standard review; and (b) expedited review. The expedited review option is available if: (a) the adverse benefit determination involves a medical condition for which the standard external review timeframe would seriously jeopardize the life or health of the Insured; and (b) the adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Insured received emergency services, but has not been discharged from a facility.