GROUP HEALTH INSURANCE PLAN
CERTIFICATE BOOKLET

Nevada

1500 (60/40) Plan

WMI Mutual Insurance Company

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This health insurance issuer believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans (e.g., the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act (e.g., the elimination of lifetime limits on benefits).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to WMI Mutual Insurance Company at 1-800-748-5340 or 801-263-8000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Schedule of Benefits

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

1. **Individual Annual Deductible and Annual Out-of-Pocket Benefits:**

(a) **Annual Deductible (Per Person):**

1500 Plan: $1500

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

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

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

1500 Plan: $3,000

(1) Except as set forth in this Schedule of Benefits or in the Policy, eligible charges will be paid at **100%** by the Company during any Calendar Year in which the applicable Out-of-Pocket amounts have been satisfied.

Only Deductible and co-insurance amounts (except co-insurance amounts paid towards Prescription Drugs and amounts paid for any Benefits which are not eligible to be paid at 100%) that are incurred by the insured person during the Calendar Year will be applied toward the satisfaction of the Individual Annual Maximum Out-of-Pocket. Amounts paid for non-covered care or treatment do not apply toward the Individual Annual Maximum Out-of-Pocket.

(2) Benefits for Prescription Drugs will always be paid in accordance with the Prescription Drug regardless of whether the Individual Annual Maximum Out-of-Pocket amount has been satisfied.

2. **Percentage of Eligible Charges payable after satisfaction of Deductible and prior to the satisfaction of the Out-of-Pocket maximum amounts for Inpatient Hospital, Outpatient Hospital, Surgical Services, Services for Severe Mental Illness, Medical services, and Services for Non-Severe Mental Illness:**

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

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

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

   All medical services covered under this Policy (except for Prescription Drugs that are covered elsewhere in the Policy under the Prescription Drug Benefit) are not subject to the Calendar Year Deductible unless and until the Company has paid a combined total of **$500** toward these services. The percentage payable for these services is as described elsewhere in this Schedule of Benefits for each corresponding service. Amounts paid by the Insured for these services prior to the satisfaction of the $500 Benefit do not apply toward the satisfaction of the Deductible amount. Amounts paid by the Insured for services for back and spine manipulations and modalities, and services for temporomandibular joint syndrome ("TMJ"), also do not apply toward the satisfaction of the Out-of-Pocket amounts**.**

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

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

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

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

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

(3) Such well-woman preventative visits as recommended by the U.S. Health Resources and Services Administration, including, but not limited to, one well-woman preventive visit per Calendar Year beginning at 14 years of age.

Inside PPO Network: 100%
Outside PPO Network: 40%

(4) Other wellness services that are not set forth in the above guidelines, including routine physical examinations and check-ups are covered, including routine lab work required for the routine physical examination.

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

(5) Immunizations that are for routine use in children, adolescents, and 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.

Inside PPO Network: 100%
Outside PPO Network: 60%

(6) For female Insureds and Dependents age nineteen (19) through age twenty-six (26), routine HPV immunizations are eligible for Benefits subject to the guidelines of the Centers for Disease Control. Eligible expenses will be processed in accordance with the Routine Physical Examination Benefit as described in the foregoing subsection (3). HPV immunizations for female Insureds and Dependents who are age eighteen (18) or younger are covered under the Benefits for routine childhood immunizations as stated elsewhere in the Schedule of Benefits. Benefits also include DNA testing for high-risk strains of HPV every three years for women who are 30 years of age or older.

Inside PPO Network: 100%
Outside PPO Network: 40%

(7) Prostate cancer screening tests, consisting of a PSA blood test and a digital rectal exam, are eligible for Benefits. Eligible expenses will be processed in accordance with the Routine Physical Examination Benefit as described in the foregoing subsection (3). Benefits are subject to the following guidelines in accordance with the American Cancer Society:

i. Once each Calendar Year, beginning at age 50, for men who have at least a 10 year life expectancy.

ii. Once each Calendar Year, beginning at age 45, if prostate cancer was diagnosed in a first-degree relative (father, brother, or son) before the relative's age of 65.

iii. Once each Calendar Year, beginning at age 40, if prostate cancer was diagnosed in two or more first-degree relatives (father, brother, or son) before the relative's age of 65.

(8) All contraceptive methods that are approved by the Food and Drug Administration ("FDA"), including insertion or extraction of FDA-approved contraceptive devices are covered (**these services are never subject to the Calendar Year Deductible, even if the $500 maximum Benefit for pre-Deductible procedures has been met**). These contraceptive methods include: (1) sterilization surgery for women; (2) surgical sterilization implant for women; (3) implantable rod; (4) IUD copper; (5) IUD with progestin; (6) shot/injection; (7) oral contraceptives (combined pill); (8) oral contraceptives (progestin only); (9) oral contraceptives extended/continuous use; (10) patches; (11) vaginal contraceptive rings; (12) diaphragm; (13) sponge; (14) cervical cap; (15) female condom; (16) spermicide; (17) emergency contraception (Plan B/Plan B One Step/Next Choice); and (18) emergency contraception (Ella). Benefits for any of these contraceptive methods will be allowed up to a 12-month supply, per prescription. Benefits also include self-administered hormonal contraception without a prescription. The Insured will not be required to use a method of contraception other than the method prescribed or ordered by the Provider.

Inside PPO Network: 100%
Outside PPO Network: 40%

(9) Screening, genetic counseling and testing for harmful mutations in the BRCA gene for women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer, or who have an ancestry associated with breast cancer susceptibility 1 and 2 gene mutations.

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

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

the U.S. Preventive Services Task Force. Other services covered include, but are not limited to, the following:

(i) Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than one year.
(ii) Screening and counseling for interpersonal and domestic violence for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services.
(iii) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases.
(iv) Prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization.
(v) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a Provider of health care.
(vi) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization.
(vii) Screening for depression.
(viii) Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the Insured or as ordered by a Provider of health care.
(ix) Smoking cessation programs for an Insured who is 18 years of age or older consisting of not more than two cessation attempts per Calendar Year and four counseling sessions per Calendar Year.

Inside PPO Network: 100%
Outside PPO Network: 40%

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

(1) Category I organ transplants and joint implants as defined in the Policy are subject to the General Limitations and Exclusions applicable to major medical expense Benefits. Category I organ transplants and joint implants must be pre-authorized by the Company in writing. The allowable amount for Implantable Hardware used for a joint implant is limited to 300% of the invoice cost, as set forth elsewhere in the Schedule of Benefits. An invoice that shows the actual cost of the implant must be submitted to the Company. Eligible diagnostic, medical and surgical expenses for a

compatible live or cadaveric donor, that are directly related to the transplant, are paid provided that the recipient of the transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under a recipient's coverage (even if both the donor and the recipient are Insureds under this Plan). Donor charges are ineligible for Benefits if the recipient is not an Insured under this Plan.

(2) Category II organ transplants must be pre-authorized by the Company in writing, and may require a consistent second opinion (and third opinion), if requested by the Company). For the purpose of this Benefit, any transplant therapy or protocol involving bone marrow shall constitute one organ even if multiple transplants are performed. This allowable amount includes payment for all transplant related costs including, but not limited to, all hospital, surgical, and medical expenses for an eligible transplant. Eligible diagnostic, medical and surgical expenses for a compatible live or cadaveric donor, that are directly related to the transplant, are paid provided that the recipient of the transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under a recipient's coverage (even if both the donor and the recipient are Insureds under this Plan). Donor charges are ineligible for Benefits if the recipient is not an Insured under this Plan. A period of eighteen (18) months must transpire before a benefit shall be allowed for a different eligible Category II organ transplant.

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

(g) **Temporomandibular Joint Syndrome Services, Upper or Lower Jaw Augmentation, Orthognathic Surgery, Reduction Procedures, or Medically Necessary Dentistry Necessitated by an Accidental Injury (as defined and limited in the Policy): 50%**. There is no 100% benefit at anytime, nor is this benefit increased after the satisfaction of the Out-of-Pocket amounts.

(h) **Ambulance services:**

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

(i) **Durable Medical Equipment:** Except as set forth below, eligible expenses are paid at **50%** and are subject to all other Policy provisions including, but not limited to, Usual and Customary allowances or PPO network allowances.

1. Eligible expenses for insulin pumps, pain management pumps and infusion-type pumps will be paid at **50%**. This limit applies regardless of whether the pumps are internal or external.

2. Eligible expenses for pacemakers are paid at the levels as for any other major medical expense.

(j) **Back and spine manipulations and modalities:** Eligible Charges are subject to a maximum Benefit payment of **$2,000** per Calendar Year. There is no 100% benefit at any time, nor is this Benefit increased after the satisfaction of the Out-of-Pocket amounts. The maximum benefit limitation for visits does not apply for treatment rendered within six (6) months of a spinal surgery.

(k) **Prosthetics:** For a natural limb or eye which is lost while insured, only the initial prosthesis is eligible for payment at **50%**.

(l) **Mammograms and Breast Imaging:**

A baseline mammogram for women between the ages of 35 and 40 is payable at:

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

The following services are payable at:

Inside PPO Network: 100%
Outside PPO Network: 40%

(1) An annual mammogram to screen for breast cancer for Insureds who are 40 years of age or older.

(2) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when Medically Necessary, as recommended by the Insured’s provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the Insured.

(3) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when Medically Necessary, as recommended by the Insured’s provider of health care to evaluate an abnormality which is:

(a) Seen or suspected from a mammogram as described above; or
(b) Detected by other means of examination.

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

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

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

(p) **Treatment for Diabetes.** Expenses related to diagnosis, monitoring, treatment, control, and education for self-management of diabetes, such as education and medical nutrition therapy, medicines, equipment and supplies are paid at **60%** (**except** for equipment that meets the definition of Durable Medical Equipment, which is paid under the Durable Medical Equipment benefit as otherwise stated in this Schedule of Benefits). Diabetic counseling, training or educational services must be provided by a licensed Provider.

(q) **Colonoscopy:**

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

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

1. Once every ten (10) years beginning at age 45.

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

3. As frequently as is determined to be Medically Necessary for follow-up colonoscopies due to the presence of colorectal cancer or adenomatous polyps.

4. For Medically Necessary reasons at any age to diagnose a medical condition.

(r) **Office Visits:**

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

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

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

(t) **Orally Administered Chemotherapy:** Coverage is subject to all Policy guidelines. This Benefit is separate from the Prescription Drug Benefit, and is not subject to Deductible.

Generic: 100% after a $25 copayment
Brand: 100% after a $100 copayment

The copayment amount does not apply after the maximum Out-of-Pocket amount has been satisfied.

3. **Family Deductible and Out-of-Pocket Benefits:**

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

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

1500 Plan: $6,000

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

B. **PRESCRIPTION DRUG BENEFIT:**

The Prescription Drug Deductible is a separate Deductible and cannot be used to satisfy the medical Deductible or medical Out-of-Pocket amounts. Drugs that are available for purchase through a retail pharmacy, but that are not purchased through the Prescription Drug Benefit, will be paid in accordance with the Prescription Drug Benefit and not as a major medical expense. They will also be limited to the maximum allowable cost, less any available discounts, that would have been available had the drugs been purchased through the Prescription Drug Benefit. Specialty and biotech medications that are considered to be self-injectable (such as, but not limited to, Avonex, Betaseron, Enbrel, Fuzeon, Imitrex, Humira, Intron, and Rebif) will be paid under the Prescription Drug Benefit even if they are administered by a Provider. All Policy provisions apply to this Benefit. Expenses related to diabetes, including insulin, testing supplies, and syringes, are paid as a major medical expense as set forth in the Schedule of Benefits and not as a Prescription Drug Benefit. The Company is entitled to any and all available rebates that are paid by Prescription Drug manufacturers.

1. **Deductible Per Person** (the Prescription Drug Deductible is waived for generic drugs)**:**

   1500 Plan: $250

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

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

C. **MENTAL ILLNESS CARE AND TREATMENT OF ALCOHOL AND SUBSTANCE ABUSE:**

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

1. **Inpatient and Outpatient treatment for Severe and non-Severe Mental Illness Care:**

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

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

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

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

"Accident" or **"Accidental Bodily Injury"** shall mean the sustaining of physical damage to the body as the result of an unexpected occurrence caused by an external force, a foreign body, or corrosive chemical, that is independent of disease or bodily infirmity and for which the Insured is not entitled to received any benefits under a workers' compensation or occupational disease law. Physical damage resulting from a normal body movement such as stooping, bending, twisting, or chewing is not considered an Accident.

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

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

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

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

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

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

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

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

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

“Company” means the WMI Mutual Insurance Company.

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

“Cosmetic” or **“Cosmetic Surgery”** means any surgical procedure performed to improve appearance or to correct a deformity without restoring a physical bodily function. Psychological factors, such as poor body image and difficult peer relations, do not constitute a bodily function.

“Covered Expenses” means those Expenses incurred by an Insured Employee or Dependent for treatment of an Injury or Illness for which the Plan provides Benefits. The term Covered Expenses also includes expenses for wellness Benefits provided under the Policy.

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

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

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

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

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

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

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

“Date Incurred” means the date services were provided.

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

“**Dependent(s)”** includes any of the following:

(a) The lawful Spouse of an Insured Employee;

(b) The Insured Employee's (or the Insured Employee's Spouse's) Child(ren) who are under age twenty-six (26);

(c) A Child who has reached the limiting age for termination of coverage, but who (1) is Disabled and dependent upon the Insured; and (2) was claimed as a Dependent on the Employee's income tax return for the previous Calendar Year, provided that the Child was enrolled in this Plan at the time of reaching the limiting age. Subsequent written proof of the continuance of such incapacity and such dependence must be furnished at such intervals as the Company may reasonably require during the first two years following such Child(ren)'s attainment of the limiting age but not more than once each year thereafter.

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

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

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

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

(c) It is primarily and customarily used for a medical purpose rather than for convenience or comfort.

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

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

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

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

"Emergency" means a 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 medicine and health, would reasonably expect the absence of immediate medical attention through a Hospital emergency department to result in: (i) placing the Insured' health, or with respect to a pregnant woman, the health of the woman or her unborn Child, in serious jeopardy; (ii) serious impairments to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

"Employee" means any person who is in an Employee/Employer relationship, is Actively at Work in the regular business of an Employer and who works an average of 80 hours per month and who receives compensation for his service from the Employer. An Employee of the subsidiaries and affiliates, if any, of the Employer named on the face of this Plan, shall be deemed an Employee of the Employer and service with any such subsidiaries and affiliates shall be deemed service with the Employer, if in compliance with hours worked. For the purpose of this definition, an owner, sole proprietor, partner, officer or director shall be considered an "Employee" provided that he or she is Actively at Work as set forth herein.

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

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

"Essential Benefits" means: 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; and 10) Pediatric services, including oral and vision care. There are no annual or lifetime dollar limits applicable to essential benefits. Any benefit-specific dollar limits referenced in the Schedule of Benefits pertain only to those health care services and supplies that are not essential benefits.

"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 a period of at least three years by the U.S. Food and Drug Administration, the American Medical Association, the Surgeon General, or any other medical society recognized by the Company, and any services, supplies, or accommodations provided in connection with such procedures.

"Extended Care Facility/Rehabilitation Care Facility" means an institution, or distinct part thereof, which is licensed pursuant to state or local law to provide extended care and treatment or rehabilitation care (whether acute care or extended care) to individuals convalescing from Injury or Illness. Any institution which is, other than incidentally, a rest

home, a home for the aged, or a place for the treatment of mental disease, substance abuse or alcoholism, is not considered an "Extended Care Facility/Rehabilitation Care Facility."

"Family Deductible" has the meaning ascribed to it in the Schedule of Benefits.

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

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

"Home Health Care" means care and treatment provided in the home of the Insured by an agency duly licensed by the state. It includes all professional services, technical and ancillary medical services, health aide services, and medical supplies and equipment which would be covered if the Insured were in a Hospital, but does not include Prescription Drugs.

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

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

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

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

(d) Qualifies as a reimbursable service under Medicare.

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

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

"Illness" means a bodily disorder resulting from disease, sickness, or malfunction of the body, or a congenital malformation which causes functional impairment, not entitling the

Employee or Dependent(s) to receive any benefits under any workers' compensation or occupational disease law. With respect to "obstetrical deliveries or sterilization", Illness means the bodily condition which permits obstetrical delivery, or sterilization.

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

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

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

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

"Insured Dependent(s)" means the Dependent(s) of an Insured Employee for whom premium is paid.

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

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

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

"Medical Claims Review Committee" means that body of the Company which provides for claims appeal.

"Medically Necessary" means any services for health care, supplies, or accommodations provided to the Insured for treatment of Illness or Injury, which:

(a) Are consistent with the symptom(s) or diagnosis;

(b) Are received in the most appropriate, cost effective, setting that can be used safely;

(c) Are not used solely for the convenience of the Insured or Provider or any other person's convenience; and

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

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

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

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

"Mental Illness" means a mental, behavioral or emotional disorder that falls under any of the diagnostic categories list in the Diagnostic and Statistical Manual (DSM), as periodically revised, other than an addictive disorder, mental retardation, irreversible dementia or a disorder caused by an abuse of alcohol or drugs, which interferes with or limits one or more major life activities of the insured. Mental Illness does not include a Severe Mental Illness as defined in this Plan.

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

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

"Open Enrollment" means the period between November 1 and December 31 during which an Employee or Dependent who previously waived coverage may enroll in the insurance Plan. An individual who enrolls in the Plan during the Open Enrollment period will become effective on January 1 of the following year. 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 as set forth and limited in the Schedule of Benefits per Calendar Year of Eligible Charges payable by an Insured to Providers. Prescription Drug costs do not apply to the Out-of-Pocket maximum amount and no individual family member may contribute more than one-half of the Family Out-of-Pocket maximum. Only Deductible and co-insurance amounts (except co-insurance amounts paid towards Prescription Drugs and amounts paid for Benefits which are not eligible to be paid at 100%) that are paid by an Insured person during the Calendar Year will be applied toward the satisfaction of Out-of-Pocket amounts. Amounts paid for non-covered care or treatment do not apply toward Out-of-Pocket amounts. 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.

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

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

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

"Policyholder" means the Employer named on the Certificate.

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

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

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

"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 discounted rates.

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

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

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

“Provider” means a Hospital, Skilled Nursing Facility, Ambulatory Service Facility, Physician, Practitioner, or other individual or organization which is licensed by the state to provide medical or surgical services, supplies, and accommodations.

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

(a) Resident beds or residential units;

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

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

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

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

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

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

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

“Schedule of Payment” means the amount of eligible Benefits provided by the Policy.

“Semi-Private Accommodation” means two-bed, three-bed, or four-bed room Accommodations in a Hospital or other licensed health care facility.

“Severe Mental Illness” means any of the following mental illnesses that are biologically based and for which diagnostic criteria are prescribed in the Diagnostic and Statistical

Manual (DSM), as periodically revised: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder.

"Special Enrollment" means an enrollment period, other than the Employer's initial enrollment period or annual Open-Enrollment period, when certain eligible Employees and Dependents are allowed 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, the state registered domestic partner of the Insured Employee, or the person who has a recognized domestic partnership that was validly formed in another jurisdiction. The Employer has the option to determine whether the Policy will offer coverage for a domestic partner.

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

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

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

"Usual and Customary" means the charge that is associated with a medical or a surgical supply, a service, a procedure or a prescription drug 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.

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

II. ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE:

This Plan covers all Employees and Dependents as defined in this Policy.

A. **Eligibility Date for Employees of Newly Enrolled Employer Groups:** Employees who worked an average of twenty (20) hours or more per week during the prior month are eligible to participate in the Plan on the Effective Date of the Employer's Plan. Employees must enroll in the Plan prior to the Employer's Effective Date. In order to enroll, Employees must submit a properly completed Enrollment card to the Company. Any Eligible Employee who does not enroll prior to the Effective Date of the Employer's Plan cannot enroll in the Plan until the next Open Enrollment period.

B. **Eligibility Date for Newly Hired Employees:** Newly hired Employees are eligible to participate in this Plan on the later of the following dates.

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

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

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

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

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

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

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

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

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

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

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

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

   (c) A newborn Child or newly adopted Child of an uninsured eligible Employee is not automatically covered from the moment of birth or placement for the purpose of adoption. The Child may be enrolled as of the first day of the month following the date of birth or the date of placement for the purpose of adoption if the Child enrolls within thirty-one (31) days of birth and if the eligible Employee enrolls at the same time.

5. Eligible Employees or Dependents who are not enrolled in this Plan may enroll upon becoming eligible for a premium assistance subsidy under Medicaid or SCHIP. The Employee or Dependent must request enrollment within sixty (60) days after eligibility for the subsidy is determined.

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

average of eighty (80) hours per month during the two (2) months immediately preceding the date he was placed on paid leave status.

III. TERMINATION OF INSURANCE BENEFITS:

A. **TERMINATION OF EMPLOYER'S COVERAGE:** An Employer's Policy will terminate on the earliest of the dates that follow.

1. The first day of the month that immediately follows the month in which the Employer ceases to participate in the Western Petroleum Marketers Association. An Employer's Policy will also terminate on the first day of the month that immediately follows the month in which they are no longer eligible to be a member of the Western Petroleum Marketers Association.

2. The first day of the month that immediately follows the month in which the Employer experiences any of the events that follow.

   (a) They cease to be an Employer.

   (b) They cease or suspend their active business operations.

   (c) They are placed in a Chapter 7 bankruptcy proceeding.

   (d) They lose their status as a business entity by means of a dissolution, an acquisition or a merger.

3. The first day of the month that immediately follows the month in which the Employer fails to pay the premium. Reinstatement of the coverage for a terminated insurance group may be allowed as long as all requirements of the Company have been met. All premiums are due on the first day of each calendar month and shall be considered delinquent on or after the 10th day of the month that they are due.

4. The first day of the month that immediately follows the month in which the Employer submits a written request to terminate their Policy.

5. The first day of the month that immediately follows the date that the Company mails a Notice of Termination of Insurance Coverage for Cause. Cause is defined as any of the situations that follow.

   (a) Submission by the Employer of any application that contains false, misleading or fraudulent information of a material nature.

   (b) Submission by the Employer or with knowledge of the Employer, of any claim that contains false, misleading, or fraudulent information of a material nature.

6. The Plan may be terminated if the number of the Employees that are insured with the Company is less than 75% of the number of the Employees that are eligible for the insurance. The Company requires that 100% of all of the Employees participate if there are five (5) or less Employees that are eligible for insurance with the Company.

7. The Plan may be terminated on any premium due date for failure to meet the participation requirements. The Company may do this by giving a written notice to the Policyholder at least thirty-one (31) days in advance.

B. **TERMINATION OF EMPLOYEE'S COVERAGE:** An Employee's coverage will terminate on the earliest of the dates that follow.

1. The last day of the month in which the Employee leaves the employ of the participating Employer.

2. The date that the Employee ceases to be an eligible Employee as that term is defined in this Plan.

3. The date of the termination of the Employer's Policy.

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

C. **TERMINATION OF DEPENDENT COVERAGE:** The Dependent's coverage 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 that term is defined in the Policy.

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

3. The date of the termination of the Employer's Policy.

4. The date of the expiration of the period for which the last premium is paid for an Employee's Dependent Coverage.

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

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

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

2. If an Employee's covered Dependent is incapable of self-support because of intellectual disability or physical handicap on the date his coverage would otherwise terminate on account of age and within thirty-one (31) days of that date the Employee submits to the Company satisfactory proof of his incapacity, his medical Benefits will be continued during the period of his incapacity. The Company may subsequently require proof of his incapacity as specified in the Plan. This extension will continue until the earliest of:

   (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; or

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

IV. COVERED SERVICES:

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

A. **INPATIENT FACILITY SERVICES:** The 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. Failure to comply will reduce all Benefits for the Inpatient facility confinement by 10%. **Pre-certification does not guarantee that payment will be made nor does it determine that Benefits are eligible.** If an Insured receives an adverse Pre-certification determination in which Benefits are denied in whole or in part, he may contact the Company to request a review. The review will be conducted in accordance with the provisions that are established by applicable law.

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

   2. Inpatient Hospital Services. The Plan covers all necessary Hospital supplies and services, for 365 days for each Disability. Room Charges are covered as a separate benefit.

   3. Inpatient Hospital Intensive Care Unit. Covered Expenses that are incurred in a Hospital Intensive Care Unit are covered up to a maximum of 180 days for each Disability.

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

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

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

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

C. **OUTPATIENT SEVERE AND NON-SEVERE MENTAL ILLNESS CARE:** Outpatient services are covered as set forth in the Schedule of Benefits. Care must be rendered by a Mental Health Care Practitioner or in a Mental Health Care Facility as defined in the Policy in order to be eligible for Benefits. Treatment rendered by a Mental Health Care Practitioner or in a Mental Health Care Facility must also meet all other criteria for eligibility subject to all other terms and provisions of the Policy in order for Benefits to be provided. Treatment that is not otherwise excluded in this policy, and which is within the scope of practice of a licensed marriage and family therapist or a social worker, is also covered.

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

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

2. Multiple or Bilateral Surgical Procedures. When multiple or bilateral surgical procedures that add significant time or complexity to patient care are performed at the same time and through the same incision, the available Benefits shall be

the value of the major procedure plus 50% of the value of the lesser procedure(s). When multiple procedures are performed through separate incisions or in separate sites, the available Benefit shall be the value of the major procedure plus 75% of the value of the lesser procedure(s). Incidental procedures, such as an incidental appendectomy, incidental scar excision, puncture of ovarian cysts, and simple lysis of adhesions are covered under the principal amount payable and no additional Benefit is available.

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

E. **MEDICAL SERVICES:**

1. Physician Consultations:

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

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

   (c) Limitations. One Physician or Provider Visit is allowed for each day. Benefits will expire after 365 days (180 days for intensive care) of Hospital confinement for each Disability.

   (d) Concurrent Physician Services:

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

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

one Physician were required due to the medical complexity of the patient's condition.

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

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

4. The Plan covers Routine Physical Examinations and check-ups as set forth in the Schedule of Benefits.

F. **HOSPICE CARE:** All services 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 to Hospice care; 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 charges do not exceed 150% of the average Semi-Private room daily rate in short term Hospitals in the area in which the Hospice is located; and (c) palliative and supportive medical and nursing services.

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

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

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

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

   For the purpose of Category II benefits, the following terms are defined as follows: (i) "Myeloablative Chemotherapy" means a dose of chemotherapy which is expected to destroy the bone marrow; (ii) "Autologous Hematopoietic Stem Cell" means an infusion of primitive cells capable of

replication and differentiation into mature blood cells which are harvested from the Insured's blood stream or bone marrow prior to the administration of the myeloablative chemotherapy; (iii) "Colony Stimulating Factor" means a substance which increases the reproduction, differentiation, and maturation of blood cellular components.

All organs for Category I and Category II transplants must be natural body organs. 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. Organs and body parts that are not specifically listed in Category I and Category II are ineligible for transplant or implant Benefits. This includes, but is not limited to, intestines.

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

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

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

K. **MATERNITY SERVICES:**

1. Maternity expenses are paid as any other Illness. In no circumstance will maternity Benefits be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. It is not necessary for a Provider to obtain authorization from the Company for a length of stay within these time limitations. Although not required, the expectant mother should 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 per pregnancy. Additional ultrasounds are allowed if they are deemed Medically Necessary by the Physician due to a condition of risk to the mother or the Child.

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

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

1. Professional and 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 blood and blood plasma are covered.

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

5. Physical therapy that is rendered by a qualified licensed professional physical therapist is covered. Physical therapy must be prescribed by a Physician or by a Physician's assistant as to the type and the duration. Physical therapy that is administered to the back and spine is only covered under the provision for back and spine manipulations and modalities.

6. Back and spine manipulations and modalities are covered. There is no 100% Benefit at any time.

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

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

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

10. Home nursing care by a registered nurse (RN) or licensed practical nurse (LPN) for a period not to exceed ninety (90) Visits in any one Calendar Year. Home nursing care is only covered when the care is required in lieu of a Hospital confinement and all of the following apply.

    (a) The care is for home Visits that are rendered outside a Hospital.

    (b) The care is ordered by the attending Physician.

(c) The care requires the technical proficiency and scientific skills of an RN or LPN.

(d) The RN or LPN is not a member of the Employee's immediate family or does not ordinarily reside in the Employee's home.

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

12. Cardiac rehabilitation therapy, such as, but not limited to, 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, and must be prescribed by a Physician. Therapy must be rendered within ninety (90) days following cardiac Illness or surgery in order to be eligible.

13. The first lens per eye that is purchased in conjunction with cataract surgery is covered as a Major Medical expense.

14. Prompt repair that is performed by a Dentist to the extent such services are Medically Necessary by reason of Accidental damage to or loss of sound natural teeth due to Accidental Injury; or for osteotomies, tumors, or cysts. For purposes of this benefit, the term Accidental damage does not include damage that results from chewing. Repair must be done within one (1) year of the Accidental Injury.

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

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

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

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

    Benefits for reconstructive breast surgery include, but are not limited to, the costs of prostheses and physical complications of a mastectomy, including lymphedemas, and benefits for outpatient chemotherapy following surgical procedures.

17. Drugs and medicines that require a Prescription Order and that are prescribed for the condition(s) for which they are approved use by the Food and Drug Administration ("FDA") are covered. Prescription Drugs do not apply to the Major Medical Deductible or to the Out-of-Pocket yearly maximum. Prescription Drugs will be paid as set forth in the Schedule of Benefits upon

submission to the Company. Mail Order drugs are only covered if they are purchased through the Prescription Drug Benefit. An equivalent Generic Drug must be used whenever one is available. If a brand name drug is purchased instead of a generic equivalent, the Insured is responsible for the price difference. This Benefit includes medication that is prescribed as part of a clinical trial, which is not the subject of the trial. This Benefit also includes coverage for early refills of topical ophthalmic products due to inadvertent wastage by the patient, and synchronized medication packs that are dispensed by a pharmacy. This Benefit also includes all FDA approved drugs to provide medication-assisted treatment for opioid use disorder and to support safe withdrawal from substance use disorder. 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 manufacturer's recommended dosage or the dosage that is established by the Food and Drug Administration ("FDA") are not covered.

Drugs and medicines that require a Prescription Order that have not been approved for use by the FDA for the specific condition for which they are being prescribed, but have been approved for use by the FDA for another condition, are eligible for Benefits if it is determined that they have been recognized as medically appropriate and effective for the treatment of the specific condition for which they are being prescribed in one or more of the following medical reference publications: the American Medical Association Drug Evaluations; the American Hospital Formulary Services Drug Information; and Drug Information for the Health Care Provider. Medical literature that has been reviewed by peers may also establish medical appropriateness. Medical literature must meet the following requirements to be acceptable.

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

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

19. Therapy for pulmonary rehabilitation is covered while under the care of a Physician. Therapy must take place in a formal rehabilitation program at an

accredited facility. The therapy must be prescribed by a Physician. Therapy must be provided within ninety (90) days following the diagnosis of pulmonary Illness or surgery in order to be eligible.

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

21. Expenses that are related to the diagnosis, the monitoring, the treatment, the control and the education for self-management of diabetes are covered. This includes expenses for education and medical nutrition therapy, for medicines, for equipment and for supplies. Expenses covered under this Benefit will be paid in accordance with the Schedule of Benefits and will be applicable toward the Major Medical deductible. Equipment that meets the definition of Durable Medical Equipment will be paid in accordance with the Durable Medical Equipment Benefit. Diabetic counseling, training or educational services must be provided by a licensed Provider.

22. Expenses for devices for contraception, including treatment or services rendered in connection with placement or removal of such devices, education and counseling relating to the use of contraception, management of side effects relating to contraception, and for any type of outpatient service for hormone replacement therapy. Expenses for Prescription Drugs for contraception or for hormone replacement therapy are eligible for Benefits.

23. Prescription vitamins (including prenatal and pediatric vitamins), in single or in combination form are covered. Prescription calcium supplements and prescription hematinics are also covered. Coverage is available for injectable and non-injectable forms of these prescriptions.

24. Expenses for the screening for, diagnosis of, and treatment of autism spectrum disorders. Treatment must be prescribed for a person diagnosed with an autism spectrum disorder by a licensed Physician or license psychologist, and must be provided for a person diagnosed with an autism spectrum disorder by a licensed Physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed Physician, psychologist or behavior analyst. Coverage includes the following:

    (a) Medically Necessary habilitative or rehabilitative care, including counseling, guidance and professional services and treatment programs including, without limitation, applied behavior analysis, that are Medically Necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of the Insured;
    (b) medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications;
    (c) psychiatric or psychological care;
    (d) behavorial therapy; and
    (e) therapeutic care that is provided by licensed or certified speech-language pathologists, occupational therapists, or physical therapists.

Treatment must be identified in a written treatment plan, which is a plan to treat an autism spectrum disorder prescribed by a licensed Physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

25. Medically Necessary care for an Insured who has been diagnosed with sickle cell disease and its variants is covered. This Benefit includes Medically Necessary Prescription Drugs to treat sickle cell disease and its variants. Necessary case management services are also available.

26. Medical treatment as part of a clinical trial or study is covered if all of the following criteria are met.

(a) The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer, or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome.
(b) The clinical trial or study is approved by: (1) An agency of the National Institutes of Health; (2) A cooperative group; (3) The Food and Drug Administration (FDA) as an application for a new investigation drug; (4) The United States Department of Veterans Affairs; or (5) The United States Department of Defense.
(c) In the case of: (1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or (2) A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner.
(d) There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study.
(e) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment.
(f) The clinical trial or study in conducted in the state of Nevada.
(g) The Insured has signed, before participating in the clinical trial or study, a statement of consent indicating that the Insured has been informed of, without limitation: (1) the procedure to be undertaken; (2) alternative methods of treatment; and (3) the risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

Coverage for medical treatment for this Benefit is limited to the following:

(a) Coverage for any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the Insured.

(b) The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the Policy.
(c) The cost of any routine health care services that would otherwise be covered under the Policy for an Insured participating in a Phase I clinical trial or study.
(d) The initial consultation to determine whether the Insured is eligible to participate in the clinical trial or study.
(e) Health care services required for the clinically appropriate monitoring of the Insured during a Phase II, Phase III or Phase IV clinical trial or study.
(f) Health care services which are required for the clinically appropriate monitoring of the Insured during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

27. Health care services that are provided through telemedicine are covered. Telehealth means the delivery of services from a Provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including facsimile or electronic mail. This Benefit includes the use of synchronous interaction or an asynchronous system of storing and forwarding information, and audio-only interaction, whether synchronous or asynchronous. 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.

28. Medically Necessary biomarker testing is covered when used for the purposes of diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration ("FDA").
(b) The indicated tests for a drug that has been approved by the FDA or the warnings and precautions included on the label of such a drug.
(c) Centers for Medicare and Medicaid Services national coverage determinations or Medicare administrative contractor local coverage determinations.
(d) Nationally recognized clinical practice guidelines or 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, a pathogenic process or pharmacological response to a specific therapeutic intervention and includes, without limitation:

(a) An interaction between a gene and a drug that is being used by or considered for use by the patient;
(b) A mutation or characteristic of a gene; and
(c) The expression of a protein.

"Biomarker testing" means the analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker, and includes, without limitation, single-analyte tests, multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

"Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(a) Made for the purpose of optimizing the outcomes of clinical care;
(b) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;
(c) Based on scientific evidence; and
(d) Made using a transparent methodology and reporting procedure.

"Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(a) Informed by a systemic review of evidence and an assessment of the risks and benefits of alternative options for care; and
(b) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

29. Medically Necessary treatment of conditions relating to gender dysphoria and gender incongruence, including psychosocial and surgical intervention and any other Medically Necessary treatment for such disorders provided by: (i) endocrinologists; (ii) pediatric endocrinologists; (iii) social workers; (iv) psychiatrists; (v) psychologists; (vi) gynecologists; (vii) speech-language pathologists; (viii) primary care physicians; (ix) advanced practice registered nurses; (x) physician assistants; and (xi) any other providers of Medically Necessary services for the treatment of gender dysphoria or gender incongruence. Coverage does not include Cosmetic Surgery. Coverage also does not include gender-affirming treatments or procedures or revisions to prior treatments if those services would not be eligible for coverage for other insured individuals for other medical conditions.

    For an Insured who is less than eighteen (18) years of age, the following requirements must be satisfied before any surgical treatments that would be eligible for coverage for treatment related to gender dysphoria or gender incongruence will be covered:

    (a) The treatment must be recommended by a psychologists, psychiatrist or other mental health professional;

(b) The treatment must be recommended by a physician;
(c) The Insured must provide a written expression of the desire to undergo treatment;
(d) A written plan for treatment that covers at least one (1) year must be developed and approved by at least two providers of health care; and
(e) Parental consent is provided for the Insured unless the Insured is expressly authorized by law to consent on his or her own behalf.

30. Coverage of testing for and the treatment of and prevention of sexually transmitted diseases, including, without limitation, Chlamydia trachomatis, gonorrhea, syphilis, human immunodeficiency virus and hepatitis B and C, for all Insureds, regardless of age. Coverage includes: (i) all FDA approved drugs for preventing the acquisition of human immunodeficiency virus or treating human immunodeficiency virus or hepatitis C; and (ii) laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus. Benefits also include coverage for condoms for Insureds who are thirteen (13) years of age or older. Benefits are at the levels as set forth in the Schedule of Benefits.

V. GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL BENEFITS:

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

1. Expenses for care or for services provided before the Insured's Effective Date or after the termination date of the Insured’s coverage.

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

3. Expenses 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 that are for any loss to which the contributing cause was the Insured's commission of, or attempt to commit, a felony for which the Insured is found guilty or is convicted in a criminal proceeding, or to which a contributing cause was the Insured's being engaged in an illegal occupation. This exclusion does not apply to acts of domestic violence.

5. Care or treatment of an Accident, an Illness or an Injury that is caused by, or that arises out of the following: riot; war; an act of war while in military, naval, or air services of any country at war; declared or undeclared war; armed aggression; or acts of aggression that are committed by the person entitled to Benefits.

6. Examinations, reports, or appearances that are in connection with legal proceedings.

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

8. Expenses in connection with transplants (except as specifically set forth in this Policy). This exclusion applies whether the Insured is the donor or is the recipient.

9. Expenses for care, for treatment or for operations which are performed primarily for Cosmetic purposes and expenses for complications of such procedures. This exclusion does not apply when expenses are incurred as a result of an Injury. This exclusion also does not apply when expenses are incurred for reconstructive surgery after a mastectomy.

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

11. Expenses in connection with the reversal of a gastric or an intestinal bypass; a balloon implant; a gastric stapling; or other similar surgical procedure.

12. Expenses in connection with genetic studies, genetic testing, or genetic counseling.

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

14. Expenses that are in excess of the Usual and Customary amount that is accepted as payment for the same service within a geographic area.

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

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

17. Expenses for electrosleep therapy or electronarcosis.

18. Expenses for the care or for the treatment of psychosexual dysfunction are not covered. This exclusion does not operate to deny Mental Illness care that is related to such condition. Mental Illness care is covered elsewhere in the Policy.

19. Expenses for the care or the treatment of learning disability and for developmental disorder are not covered. Expenses for the care or the treatment of intellectual disability, for chronic organic brain syndrome, and for personality disorder are also not covered. Expenses for treatment or care 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.

20. Expenses for the alleviation of chronic intractable pain by a pain control center or in a pain control program to the extent that those expenses exceed the Usual and Customary expenses for Semi-Private room accommodations. Expenses also cannot be in excess of either one (1) hour of psychotherapy for each day or ninety minutes of group therapy for each day.

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

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

23. Expenses for rest cures.

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

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

26. 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".)

27. Expenses for services 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 resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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

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

30. Expenses for any services or products unless the services or products were both of the following.

    (a) Medically Necessary.

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

31. Expenses for training, educating, or counseling a patient. This exclusion does not apply when such services are incidentally provided (without a separate expense) in

connection with other Covered Services. This exclusion also does not apply when the services are Medically Necessary and they are specifically prescribed by a Physician.

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

33. Expenses associated with speech therapy. This exclusion does not apply when such services are required to restore to function speech loss or impediments due to Illness or Injury.

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

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

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

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

35. Expenses incurred for diagnostic purposes that 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.

36. Expenses for (i) Routine Physical Examinations for Insureds which exceed the guidelines set forth in this Policy or the Schedule of Benefits; (ii) x-ray or laboratory procedures when there are no symptoms of Illness or Injury, unless they are covered as part of the Routine Physical Examination Benefit; or (iii) mental examinations or psychological tests when there are no symptoms of Mental Illness.

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

38. Expenses for appointments scheduled and not kept.

39. Expenses for telephone consultations, whether they are initiated by the Insured or the Provider, are not covered unless they are provided in accordance with the provisions for telemedicine as covered elsewhere in the Policy.

40. Expenses for the care and treatment of: teeth; gums; alveolar process; dentures; dental appliances; or supplies used in such care and treatment, except as specifically provided for by the terms of the Plan or in the Schedule of Benefits. Such expenses may be considered for Benefits under the Dental Policy if Dental coverage has been selected and premiums have been paid.

41. Expenses in connection with Medically Necessary treatment of temporomandibular joint syndrome ("TMJ") except as specifically provided in the Schedule of Benefits.

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

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

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

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

46. Expenses for the following.

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

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

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

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

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

49. Expenses for acupuncture or acupressure.

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

51. Expenses for preventative medication, non-prescription vitamins, mineral and nutrient supplements, fluoride supplements, food supplements, sports therapy equipment, and the services and applications of such. Notwithstanding the foregoing exclusion, the Policy will provide Benefits up to an annual maximum amount of **$2,500** for special food products which are prescribed or ordered by a Physician as Medically Necessary treatment for a person with inherited metabolic diseases characterized by deficient metabolism, or malabsorbtion originating from congenital

defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat.

52. Expenses for anabolic steroids; weight-reduction drugs; growth hormones; and hematinics without a prescription.

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

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

55. Expenses for autopsy procedures.

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

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

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

59. Expenses that are related to treatment for infertility, including Prescription Drugs and medications.

60. Expenses for massage therapy.

61. Expenses for Occupational Therapy, except as set forth elsewhere in the Policy.

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

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

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

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

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

medication errors, administration of the incorrect blood type, and bedsores that are acquired in the Hospital.

67. Expenses for sex change surgery or sex reassignment surgery are not covered. This exclusion does not operate to deny any services that are part of a sex reassignment surgery if those services are eligible for coverage for other insured individuals for other medical conditions.

VI. COBRA, USERRA, AND COVERAGE DURING DISABILITY:

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

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

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

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

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

Coverage may be continued for up to 36 months for the spouse and or Dependent Child(ren) if group health coverage is lost due to the Employee's death, divorce,

legal separation, the Employee's becoming entitled to Medicare, or because of loss of status as a Dependent Child under the Plan.

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

1. If an Employee or Dependent is disabled (as determined by the Social Security Administration) at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation period for all qualified beneficiaries is 29 months from the date of termination of employment or reduction in hours. For the 29-month continuation period to apply, written notice of the determination of disability must be provided to the Employer within both the 18-month coverage period and within 60 days after the date of the determination.
2. If a second qualifying event occurs during the 18-month or 29-month continuation coverage period which would give rise to a 36-month period for the spouse and/or Dependent Child(ren) (for example, the Employee dies or becomes divorced) then the maximum coverage period for a spouse and/or Dependent Child(ren) becomes 36 months from the date of the initial termination of employment or reduction in hours. For the 36-month continuation period to apply, written notice of the second qualifying event must be provided to the Employer within 60 days after the date of the event.
3. If the qualifying event occurs within 18 months after the Employee becomes entitled to Medicare, then the maximum coverage period for the spouse and/or Dependent Child(ren) is 36 months from the date that the Employee became entitled to Medicare.

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

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

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

B. **The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"):** If an Insured Employee is absent from employment due to service in the uniformed services, federal law provides that the Employee and his dependents are entitled to continue health insurance coverage for a period of up to twenty-four

(24) months. Election of the continuation coverage must be made in writing within sixty (60) days of the date of commencement of any leave for military service.

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

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

The term "uniformed services" means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

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

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

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

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

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

    (c) The Disabled person becomes insured or covered under any other group medical benefit or service plan or self-funded plan.

2. Non-Disability related expenses: Coverage for an Insured Employee and his Dependents under this section shall continue during such time as the Insured Employee or Dependent is on leave without pay as a result of a Total Disability. The coverage shall be identical to the coverage in existence prior to such Disability, except insofar as it shall exclude any Injury or Illness related to the Total Disability which is covered as set forth in this Policy. The coverage shall continue until the earliest of the following dates:

    (a) The employment of the Employee is terminated;

(b) The Employee or Dependent obtains another policy of health insurance;

(c) The group Policy of insurance is terminated; or

(d) The expiration of a period of twelve (12) months.

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

A. COORDINATION OF BENEFITS:

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

   (a) Group insurance or group-type coverage, whether insured or uninsured, 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 required or provided by law, except a state plan under Medicaid or under any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

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

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

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

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

      1. The benefits of the health care plan which covers the person (to whom the claims relate) as other than a Dependents 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); and

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

   NOTE: If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child(ren), and the entity obligated to pay or provide the benefits of the health care plan of that parent has actual knowledge of those terms, the benefits of that health care plan are determined first. 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 IX, A(2)(c)(2) shall apply.

4. When the person (to whom the claim relates) is an Employee who is laid off or retired, or is a Dependent of such an Employee, the benefits of the other health care plan shall be determined before those of this Plan. If the other health care plan does not have this rule, and if, as a result, there is not an agreement between this Plan and the other health care plan on the order of benefits, this rule is ignored.

5. 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 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 Insured Employee or the Insured Dependent, including from

future claim payments due for services incurred by the Insured or any Insured member of the Insured's family, without regard to the identity or nature of the Provider of care, insurance companies, or other organizations.

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

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

1. Recovery Rights: The Company shall be entitled to the proceeds of any settlement or judgment that results in a recovery from the third party. This recovery shall be up to the amount of Benefits paid for the Illness or Injury. The Company's rights of recovery can only be enforced after the Insured has been made whole for his Injuries or Illness.

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

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

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

C. **PERSONS COVERED BY MEDICARE:**

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

   (a) An active Employee who is age sixty-five (65) or older and 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 required by federal law during which Medicare is the secondary payer to a group health plan and the Insured individual is receiving treatment for end-stage renal disease (ESRD).

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

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

   (a) For all other Insured persons.

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

This Policy complies with TEFRA and DEFRA for all Insured persons also covered by Medicare.

IX. GENERAL POLICY INFORMATION:

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

1. The number of Insured Employees 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 in effect on such premium due date. Applicable rates are available from the Company upon request.

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

1. On any premium due date by giving written notice to the group Policyholder at least thirty-one (31) days prior to such premium due date.

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

Premiums may also be computed by any method that is mutually acceptable 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 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 then due and unpaid. That amount shall include a *pro rata* premium for the period that commences with the last premium due date and ending with such date of termination.

E. **RECORD OF EMPLOYEES INSURED:** The Company shall maintain a record which shall show at all times the names of all Insured Employees, the beneficiary designated by each Employee, if any, the date when each Employee became Insured and the Effective Date of any change in coverage. This record shall also show any other information that may be required to administer the insurance. The Company shall furnish a copy of this record to the Policyholder, upon request. The Policyholder shall give the Company any information that is required for administering the insurance. This information shall include, but is not limited to, information for enrolling Employees, changes in coverage, and termination of insurance. Any records of the Employer and/or Policyholder that may have a bearing on this insurance shall be open for inspection by the Company at a reasonable time.

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

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

H. **CLAIM AND APPEAL PROCEDURES:**

Following is a description of how the Plan processes claims and appeals. A claim is defined as any request for a Plan Benefit, made by an Insured or a representative of an Insured, that complies with the Plan’s procedures for making a claim. There are

two types of claims: pre-service and post-service. The different types of claims are described below. Each type of claim has a specific time period for approval, request for further information or denial, as well as specific time periods for appeal reviews. Time periods begin at the time that a claim is filed, and "days" refers to calendar days.

Pre-Service Claim

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

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

Post-Service Claim

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

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

Notice to Insured of Adverse Benefit Determination

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

(10) working days of the claim determination, and will set forth the appeals procedures that are available to the Insured.

Appeals

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

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

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

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

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

Independent External Review

If the Company issues a final adverse benefit determination of an Insured's request to provide or pay for a health care service or supply, he may have the right to have the decision reviewed by health care professionals who have no association with the Company. An Insured has this right only if the denial decision involved:

- The medical necessity, appropriateness, health care setting, or level of care or effectiveness of a health care service or supply, or
- The determination the health care service or supply was experimental or investigational.

An Insured must first exhaust the Company's internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless the Insured requested or agreed to a delay, the Company's failure to respond to a standard appeal within 30 days in writing. The Company may also agree to waive the exhaustion requirement for an external review request.

A request for an external review must be submitted to:

Office for Consumer Health Assistance
555 E. Washington Avenue, Suite 4800
Las Vegas, NV 89101

An Insured may also call the Office for Consumer Health Assistance for help at (702) 486-3587 or (888) 333-1597.

An Insured may represent himself in his request or he may name another person, including his treating health care provider, to act as his authorized representative for his request.

An Insured's external review request must include a completed form authorizing the release of any of his medical records the independent review organization ("IRO") may require to reach a decision on the external review.

If an Insured's request qualifies for external review, the Company's final adverse benefit determination will be reviewed by an IRO selected by the Office for Consumer Health Assistance. The Company will pay the costs of the review.

The decision of an IRO concerning a request for external review must be based on: (a) documentary evidence, including any recommendation of the physician of the Insured; (b) medical or scientific evidence, including, without limitation: (i) professional standards of safety and effectiveness for diagnosis, care and treatment that are generally recognized in the United States; (ii) any report published in literature that is peer-reviewed; (iii) evidence-based medicine, including, without limitation, reports and guidelines that are published by professional organizations that are recognized nationally and that include supporting scientific data; and (c) the terms and conditions for benefits set forth in the Policy.

For the purposes of this section, "Medical or Scientific Evidence" means evidence found in the following sources:

1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Library of Medicine of the National Institutes of Health for indexing in Index Medicus (MEDLINE) and Elsevier for indexing in Excerpta Medica (EMBASE);
3) Medical journals recognized by the Secretary of Health and Human Services pursuant to section 1861(t)(2) of the Social Security Act, 42 U.S.C. § 1395x;
4) The following standard reference compendia:
    a) AHFS Drug Information published by the American Society of Health-System Pharmacists;
    b) Drug Facts and Comparisons published by Wolters-Kluwers Health;
    c) Accepted Dental Therapeutics published by the American Dental Association; and
    d) The United States Pharmacopoeia's Drug Quality and Information Program;
5) Findings, studies or research conducted by or under the auspices of the Federal Government and nationally recognized federal research institutes, including, without limitation:
    a) The Agency for Healthcare Research and Quality;
    b) The National Institutes of Health;
    c) The National Cancer Institute;
    d) The National Academy of Sciences of the National Academies;
    e) The Centers for Medicare and Medicaid Services;
    f) The Food and Drug Administration; and
    g) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6) Any other source of medical or scientific evidence that is comparable to the sources listed in subsections 1 to 5 above, inclusive.

Standard External Review Request for Adverse Benefit Determinations involving Medical Necessity: An Insured, an authorized representative, or the physician of the Insured, must file a written external review request within four months after the date the Company issues a final notice of denial.

Within five business days after receiving an Insured's request for external review, the Office for Consumer Health Assistance ("OCHA") shall notify the Insured, the authorized representative or the physician of the Insured, and the Company that the request has been filed.

As soon as practicable after receiving the request, the OCHA shall assign an IRO to conduct the review. Within five business days after receiving notification that an IRO has been assigned, the Company shall provide to the IRO all documents and

materials relating to the adverse determination. Within five days after receiving the documents and materials, the IRO shall notify the Insured, the physician of the Insured, and the Company if any additional information is required to conduct the external review.

Within 15 days after receipt of the information necessary to make a determination, the IRO shall approve, modify or reverse the adverse determination. The IRO shall submit a copy of its determination, including the reasons therefore, to the Insured, the physician of the Insured, to the authorized representative of the Insured, if any, and to the Company.

Expedited External Review Request for Adverse Benefit Determinations involving Medical Necessity: The OCHA shall approve or deny a request for an external review of an adverse benefit determination in an expedited manner not later than seventy-two (72) hours after it receives proof from the provider of health care of the Insured that:

1. 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; or
2. Failure to proceed in an expedited manner may jeopardize the life or health of the Insured or the ability of the Insured to regain maximum function.

If the OCHA approves a request for external review, it shall assign the request to an IRO not later than 1 business day after approving the request. Within twenty-four (24) hours after receiving notice of the OCHA assigning the request, the Company shall provide to the IRO all documents and materials relating to the adverse benefit determination. The IRO shall complete its external review not later than forty-eight (48) hours after receiving the assignment, unless the Insured and the Company agree to a longer period. Within twenty-four (24) hours after completing the review, the IRO shall notify the Insured, the physician of the Insured, the authorized representative, if any, and the Company by telephone, of its determination, and shall submit a written decision of its external review not later than forty-eight (48) hours after completing the review.

Standard and Expedited External Review Request for Adverse Benefit Determinations involving Experimental/Investigational Services or Treatment: An Insured, an authorized representative, or the physician of the Insured, must file a request for external review within four months after the date the Company issues a final notice of denial. A request for standard external review must be filed in writing. A request for an expedited external review may be filed in writing or may be filed orally if the Insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

Within one business day after receipt of the request for a standard review (immediately in the case of an expedited review), the OCHA shall notify the Company. Within five business days after receipt of the notice from the OCHA

(immediately in the case of an expedited review), the Company shall conduct and complete a review of the request to determine whether:

1. The individual is or was an Insured in the health benefit plan at the time the health care service was recommended or requested or, in the case of a retrospective review, was an Insured in the health benefit plan at the time the health care services or treatment was provided;
2. The recommended or requested health care service or treatment that is the subject of adverse benefit determination: (a) would be a covered benefit under the health benefit plan but for the Company's determination that the health care service or treatment is experimental or investigation for a particular medical condition; and (b) is not explicitly listed as an excluded benefit under the health benefit plan;
3. The Insured's treating physician has certified that one of the following situations is applicable: (a) standard health care services or treatments have not been effective in improving the Insured's condition; (b) standard health care services or treatments are not medically appropriate for the Insured; or (c) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
4. The Insured's treating physician: (a) has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the Insured, in the physician's opinion, than any available standard health care services or treatments; or (b) who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the Insured's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to the Insured than any available standard health care services or treatments;
5. The Insured has exhausted the Company's internal grievance process, unless the Insured is not required to exhaust the Company internal grievance process; and
6. The Insured has provided all the information and forms required to process the review.

Within one business day after completion of the eligibility review, the carrier shall notify the OCHA and the Insured in writing whether the request is complete and whether the request is eligible for independent review. If the request is not complete, the carrier shall inform the Insured and the OCHA in writing what information or materials are needed to make the request complete. If the request is not eligible for independent review, the carrier shall inform the Insured and the OCHA in writing the reasons for ineligibility and shall inform the Insured that the determination may be appealed to the OCHA.

Within one business day after receipt of the notice from the Company that the external review request is eligible, the OCHA shall assign an IRO, shall notify the Company of the name of the IRO, and shall notify the Insured, in writing, that the Insured may submit in writing to the IRO any additional information that the IRO shall consider when conducting the review. Within one business day after receipt of the request, the IRO shall select one or more clinical reviewers to conduct the review. Each clinical reviewer shall provide to the IRO a written opinion within

twenty (20) calendar days (within five calendar days for an expedited review). The IRO shall make a decision based on the clinical reviewer's opinion within twenty (20) calendar days (within forty-eight (48) hours for an expedited review) of receiving the opinion and shall notify the Insured, the Company, and the OCHA. Upon receipt of a notice reversing the adverse benefit determination, the Company shall within one business day approve the coverage that was the subject of the adverse benefit determination.

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.

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

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

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

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

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

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

instrument containing such statement is, or has been, furnished to such Employee or to his beneficiary.

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

O. **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 Employee or Insured Dependent. Notice given to any authorized agent of the Company shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in the Plan shall not invalidate any claim if it is shown that it was not reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

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

P. **EXAMINATION:** The Company shall have the right and the 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 the 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.

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

   All Benefits are payable to the Employee. If any such Benefits remains 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 any one or more

of the following relatives of the Employee: spouse; parent; child(ren); or sibling(s). Any payments made will constitute a complete discharge of the Company's obligations to the extent of such payment. The Company will not be required to see the application of the money so paid.

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

S. **OVERPAYMENTS:** If for any reason the Company pays any amounts to, or on behalf of, the Insured for (i) services not covered under this Plan; (ii) services which exceed amounts to be paid as Benefits under this Plan; or (iii) services on behalf of a person believed to be a Dependent who is not covered under this Plan, the Company may, at its discretion, recover overpayments from one or more of the persons it has paid or for whom it has paid. The Company may also recover overpayments from future claim payments made to the same provider for services that are rendered to the same Insured.

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

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

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

The Company shall have the sole discretion to construe and interpret the terms and provisions of the Plan and to determine eligibility for benefits. Nothing in the foregoing statement limits the rights of the Insured to protections under the federal law known as ERISA, including, but not limited to, rights of appeal and rights to bring suit in state or federal court.

W. **PREFERRED PROVIDER ORGANIZATION ("PPO"):** If you obtain services from a preferred provider, eligible Benefits will be processed according to the

preferred provider discounted rate, and will be reimbursed at a higher percentage level. A directory of PPO providers is available from the Company, free of charge. You may also obtain services from a non-preferred provider, however, eligible Benefits will be processed according to the Usual and Customary rate and will be reimbursed at a lower percentage level.

If there is a service which a Preferred Provider of this Plan does not provide, and the Provider who is treating the Insured requests the service, and the Company determines that the use of the service is necessary for the health of the Insured, the service shall be deemed to be provided by a Preferred Provider under the Plan and Benefits will be provided accordingly. If an Insured is confined in a facility which is a Preferred Provider of health care at a time when the facility terminates its agreement with the insurer, or if an Insured obtains confirmation that a Provider is a Preferred Provider and the Provider subsequently terminates its Preferred Provider status, coverage will be provided for the period of confinement at the rate negotiated for that Provider before it terminated its agreement and at no additional cost to the Insured. It is the Insured's responsibility to verify whether a Provider of health care is a Preferred Provider of health care.

If an Insured is receiving medical treatment for a medical condition from a Preferred Provider whose contract is terminated during the course of medical treatment for a reason other than medical incompetence or professional misconduct, the Insured may continue to obtain medical treatment for the medical condition from such Provider if: (1) the Insured is actively undergoing a medically necessary course of treatment; and (2) the Provider and the Insured agree that the continuity of care is desirable. The Provider is entitled to receive reimbursement from the Company for the medical treatment pursuant to this section, if the Provider agrees to: (1) provide medical treatment under the terms of the PPO contract, including, without limitation, the rates of payment for providing medical service as those terms existed before the termination of the PPO contract; and (2) not seek payment from the Insured for any medical service that the Provider could not have received from the Insured if the Provider was still under the PPO contract. Such coverage must be provided until the later of: (1) the 120th day after the date the PPO contract is terminated; or (2) if the medical condition is pregnancy, the 45th day after (a) the date of delivery; or (b) if the pregnancy does not end in delivery, the date of the end of the pregnancy.

No Surprises Act Provisions

If an Insured receives Emergency services at a non-PPO facility, receives Emergency services at a PPO facility but by a non-PPO Provider within such facility, or receives Eligible Charges for air Ambulance services from a non-PPO provider, Benefits 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. This includes post-stabilization services, unless you give written consent and give up your protections to not be balance billed for such services.

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.

If an Insured is receiving treatment from a Preferred Provider whose contract is terminated during the course of the treatment for a reason other than for fraud or for failure to meet quality standards, the Insured may continue to obtain treatment from such Provider if the Insured is undergoing a course of treatment for: (1) an acute Illness that requires specialized treatment to avoid the reasonable possibility of death or permanent harm; or (2) a chronic Illness which is life-threatening, degenerative; potentially disabling or congenital, and which requires specialized medical care over a prolonged period of time. Benefits for such treatment will be processed at the PPO cost sharing level. Such coverage must be provided until the earlier of: (1) 90 days; or (2) the date the Insured no longer requires such continuing care.

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

Y. **HEALTH CARE COST CONTROLS:** This Policy attempts to control health care costs through several methods. Insureds are encouraged to use, if medically appropriate, the services and the facilities that are the most efficient or that tend to control or reduce the cost of health care. The following programs are ones that constitute the Company's efforts to control health care costs.

1. Preferred Provider Networks. The Company receives discounts through Preferred Provider Networks. These discounts are then passed back to Insureds in the form of a higher benefit percentage and write-offs.

2. Utilization Management. All inpatient hospitalizations are required to be pre-certified in order to establish the medical necessity of the procedure. Pre-certification does not guarantee that payment will be made. Failure to comply will reduce all Benefits for the hospital Confinement by 10%.

3. Case Management. The Company controls the costs that are associated with catastrophic and chronic care by monitoring the course of treatment and intervening when it is necessary.

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

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

X. PRIVACY POLICY

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

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

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

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

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

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

WMI Mutual Insurance Company

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