THE NATIONAL MUTUAL INSURANCE COMPANY
Employee Group HRA Health Plan

EFFECTIVE DATE
January 1, 2010

REVISED
January 1, 2011

FOR COVERAGE INQUIRIES OR TO CONTACT THE CLAIMS ADMINISTRATOR:

MUTUAL HEALTH SERVICES
P.O. Box 4138
Akron, Ohio 44321
Phone: (330) 666-0337 or 1-800-367-3762 National Toll Free
PLAN AMENDMENT #1
THE NATIONAL MUTUAL INSURANCE COMPANY
Employee Group HRA Health Plan


PREview managed care program administered by the PREview Utilization Management Department of Medical Mutual shall be removed and replaced with the utilization management of American Health Holdings. The new language shall be as follows:

PRECERTIFICATION OF BENEFITS

FOR INPATIENT HOSPITAL CONFINEMENT

This Plan is designed to assist you, your Physician and your Hospital to contain costs, while providing you with full, Medically Necessary care.

When you or your eligible Dependent are scheduled for any non-emergency surgical procedure, which would require an inpatient Hospital stay, including pregnancy admittance, you must call the utilization review company American Health Holdings.

NOTIFICATION OF HOSPITAL ADMISSION

Elective Admissions

An elective Hospital admission refers to a pre-planned admission to the Hospital for an overnight stay or longer. Patients are required to give notice to American Health Holdings within 48 hours of all elective admissions, except pregnancies, prior to admission.

Emergency Admissions

An emergency/urgent admission refers to a situation that requires immediate Hospitalization. In such case, the patient must call American Health Holdings within 72 hours of admission and provide them with the pertinent information concerning the admission.

Pregnancy/Childbirth

Special notification rules apply, as follows:

• Inpatient Confinement for Delivery of Child – American Health Holdings must be notified only if the inpatient care for the mother or child is expected to continue beyond:
  • 48 hours following a normal vaginal delivery, or
  • 96 hours following a cesarean section.
  • For inpatient care (for either the mother or child) which continues beyond the 48/96 hour limits stated above, American Health Holdings must be notified before the end of these time periods.
- **Non-Emergency Inpatient Confinement Without Delivery of Child** - Confinement during pregnancy but before the admission delivery, which is not Emergency Care, requires notification as a scheduled Confinement. American Health Holdings must be notified prior to the scheduled admission.

**AMERICAN HEALTH HOLDINGS**
1-800-349-8587

**Retrospective Review**

A retrospective review of the Medical Necessity of both the hospital stay, as well as the length of stay will be performed when the patient was not identified to the review organization in a timely manner to permit a preadmission or emergency review. If it is determined that the Plan Participant could not reasonably ensure that the required procedures for timely notification could be met then the results of the retrospective review will be honored with no additional penalties.

The following information will be required:

- Employee's Name
- Patient's Name
- Name of Hospital and Date of Admission
- Admitting Diagnosis
- Estimated Length of Stay

**Please Note:** Notification of a Hospital admission does not guarantee benefit payment under the Plan. If preadmission Hospital certification is not utilized, your benefits under the plan will be reduced by $200.00.

This Amendment takes effect on January 1, 2012. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

The National Mutual Insurance Company adopts the terms and conditions set forth in this Amendment active on the Effective Date, regardless of the date signed below.

[Signature]
Signature on behalf of the Plan

[Printed Name and Title]
Superior Treasurer

[Date]
11/21/2011
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INTRODUCTION

This booklet (otherwise known as the "Summary Plan Description" or "SPD") describes the health care benefits provided by The National Mutual Insurance Company for Eligible Employees and their covered Dependents. We encourage you to take the time to become familiar with this document and how best to utilize the benefits available to you.

You will find terms starting with capital letters throughout this booklet. To help you understand your benefits, most of these terms are defined in the Definitions section at the end of the booklet. As used in this booklet, the terms "you" and "your" refer to Employees eligible to participate in The National Mutual Insurance Company Group Health Plan (the "Plan").

This Plan is a self-funded benefit plan. The National Mutual Insurance Company has retained the services of a professional Claims Administrator to perform the day-to-day claims administration of the Plan, but the ultimate risk of loss belongs to The National Mutual Insurance Company. The National Mutual Insurance Company, as Plan Administrator, has the final, sole discretion to interpret the Plan, decide any questions of eligibility, and determine any benefits which are payable under the Plan.

While The National Mutual Insurance Company expects in good faith to continue this Plan indefinitely, it reserves the right to amend, suspend, or terminate the Plan in whole or in part, at any time, with or without advance notice. Any amendment or modification to the Plan must be made in writing, properly adopted, and signed by an authorized representative of The National Mutual Insurance Company.

ELIGIBILITY

Upon enrollment in the Plan you, your Spouse, and your eligible Dependents shall become Participants eligible for the benefits provided by this Plan, subject to the limitations contained in the applicable Plan provisions.

EMPLOYEE ELIGIBILITY AND EFFECTIVE DATES

All active, full-time, regular Employees are eligible to participate in this Plan on the date of hire. Coverage begins on the date of hire, provided the Employee has submitted a completed enrollment form to the Benefits Department within 31 days of that date.

All active, full-time or part-time, regular Employees who:

1. have returned to work for The National Mutual Insurance Company after retirement from The National Mutual Insurance Company, and

2. on the day before the date of re-hire, were participants in The National Mutual Insurance Company Retiree Group Health Plan,

are eligible to participate in this Plan on the date of re-hire, regardless how many hours they work. Coverage begins on the date of re-hire, provided the returning Employee has submitted a completed enrollment form to the Benefits Department within 31 days of that date.
Spouse and Dependent Eligibility

Dependent Spouses must first utilize their employer's medical plans if coverage is available to them at any cost. Working spouses must elect coverage through his or her employment as follows:

- If the spouse of a Plan Participant is employed by an employer that provides, or will provide upon proper application and contribution, health care benefits for either single or family coverage, said spouse must apply for and accept such coverage. Failure to obtain such health coverage shall result in The National Mutual Insurance Company providing only secondary coverage for the eligible Spouse, as if the Spouse had enrolled in their employer's plan.

Please refer to the Spouse Eligibility Rule Form, included with your enrollment packet, for additional details.

DEPENDENT ELIGIBILITY

You may enroll yourself alone or you and your Dependent(s). A Dependent includes:

- Lawful Spouse (marriage between a man and a woman) of an Employee who is not legally separated from the Employee. (A common law husband or wife is not eligible to participate in this Plan);

- Your natural child, step-child or adopted child including any child placed for adoption with you. Children who meet this definition are eligible for coverage from birth to the end of the month of their 26th birthday, as long as they do not have other coverage available to them through their own employer.

- Your Dependent children who reside* with you are eligible for coverage if they are incapable of self-support by reason of a mental or physical handicap which commenced prior to losing coverage at age 26, and they continue to be incapable of self-support and are principally dependent upon you or your Spouse for support. However, notification of the child's condition must be given within 31 days of the child's normal termination date. A non-permanent condition where medical improvement is possible is not considered to be a "handicap" for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

*In this scenario "reside" includes either natural parent regardless of divorce

An Eligible Dependent does not include:

- A Spouse who is legally divorced or separated from the Employee;
- Any person who is on active duty in the military service;
- Any person who resides outside of the United States or Canada;
- Foster child;
- Grandchildren unless Employee has assumed legal guardianship of them.

Eligibility for Disabled Children

In order for a disabled Dependent child to be eligible for coverage under the Plan after the end of the month of his or her 26th birthday, they:
must be enrolled in the Plan prior to age 26,

must be incapable of self-support because of mental retardation or a permanent, chronic, and total disability which commenced prior to age 26,

must be principally supported by the Employee, and

must be continuously disabled and covered thereafter.

If you believe a covered Dependent meets the disability criteria above, obtain a statement from the attending Physician indicating the complete diagnosis and prognosis of the covered Dependent. This information must be submitted to the Benefits Department within 31 days of the date the covered Dependent attains age 26. This information will be reviewed to determine eligibility for continued benefits under the Plan. You may be required to submit additional information in connection with the eligibility determination.

You will be notified if the covered Dependent is eligible for benefits under the Plan as a disabled Dependent child.

**VERIFICATION OF INCAPACITATED DEPENDENT STATUS**

The Claims Administrator may require, at reasonable intervals, subsequent proof that such Dependent child continues to be an incapacitated Dependent. The Claims Administrator reserves the right to have such incapacitated Dependent examined by a Physician of the Plan's choice, at the Plan's expense, to determine that the incapacitated Dependent is or continues to be incapable of self-support. Coverage under the Plan will cease when such Dependent child ceases to be an incapacitated Dependent, or when such Dependent child ceases to meet the requirements to be considered a Dependent under the Plan. Once a child ceases to be eligible, that child cannot be re-enrolled in the Plan.

**VERIFICATION OF DEPENDENT STATUS**

The Claims Administrator may require documentation proving Dependent status, including, but not limited to, birth certificates, marriage records, a guardianship order or initiation of legal proceedings severing spousal or parental rights.

If both Spouses are Employees of The National Mutual Insurance Company or one is an Employee and one is covered by The National Mutual Insurance Company Retiree Plan, both may elect coverage, but only one may elect Dependent coverage. In no event may an individual be covered both as an Employee or Retiree and as a Dependent under the Plan. Dependent children may be covered as Dependents of either Spouse, but not both. In no event will a Dependent's coverage become effective before an Employee's or Retiree's coverage.

In compliance with the Omnibus Budget Reconciliation Act (OBRA) of 1993, the following provisions apply to Dependent coverage:

- Adopted children are eligible for coverage immediately upon placement with the family and are not subject to the Pre-existing Conditions limitations of the Plan.

- If an eligible Employee who is covered under this Plan is divorced, the children of that Employee are eligible Dependents for the Plan, regardless of other Dependent qualifications, if the eligible Employee is court ordered to provide coverage. If the eligible Employee or legal Spouse has obtained a Qualified Medical Child Support Order
The National Mutual Insurance Company

(QMCSO), coverage will also be provided. The Dependent may not be terminated from coverage as long as the Employee is eligible for coverage and the court order is still in effect.

ILLEGAL ALIEN

Eligible Dependent shall not include any Illegal Alien. For purposes of this Plan, Illegal Alien shall mean a person who (1) is not a citizen of the United States, (2) is not lawfully admitted to the United States for permanent residence, and (3) is not authorized for employment within the United States by the United States Immigration and Naturalization Service or the Attorney General of the United States.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If you are required by a "Qualified Medical Child Support Order", as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for your children, you can enroll these children as timely enrollees as required by OBRA 93. If you are not already enrolled in the Plan, you must also enroll at the same time.

When the Plan Administrator receives an order by a court or other authorized state agency for an Employee to provide coverage for his or her child(ren), the Plan Administrator will review the order to determine whether it is a "Qualified Medical Child Support Order", entitled to enforcement by the Plan. The Plan's procedures for reviewing these orders are available, without charge, upon written request to the Plan Administrator.

ENROLLMENT IN THE PLAN

The Employee is required to complete an enrollment form and the Benefits Department must receive this form within 31 days from the date you are eligible to enroll. Received means tendered by U.S. mail and postmarked no later than 31 days from the eligibility date.

The Employee shall furnish such information regarding his age, family status and other relevant matters as may be required. If the Employee enrolls after the initial 31-day enrollment period, you must wait until the next annual enrollment period or until you incur a change in family status.

If the Employee enrolls himself and his Dependents when first eligible, coverage will commence as stated under the Employee Eligibility and Effective Dates section listed on page 3.

NOTE: Newborn children: If the Plan Participant has previously enrolled in Dependent coverage and continues to cover his or her eligible Dependents, newborns will be eligible under this plan on the date of birth. However, no claims will be paid until a completed enrollment form is received by the Claims Administrator.

Plan Participants who have not previously enrolled for Dependent coverage will be required to complete and submit an enrollment form for the newborn within 31 days of the child's birth for the child to be considered for coverage.

EMPLOYEE PREMIUMS

The Plan participant's contributions for health coverage may be discounted if the participant qualifies through the company's discount program.

If it is unreasonably difficult due to a medical condition for the covered person to meet the requirements under the discount program, we will make a reasonable alternative standard for
you to obtain the discount. Currently, if you complete an employer-approved smoking cessation program you will be eligible for a premium discount. Please contact the company's benefits administrator for more information.

SECTION 125

This Plan is part of The National Mutual Insurance Company's Section 125 flexible benefits plan that allows you to elect health care coverage and pay your share of the cost of coverage on a pre-tax basis. This tax-saving advantage allows you to have a portion of your weekly compensation deducted from your paycheck before your taxes are calculated. In this way, you pay for your health care coverage with pre-tax dollars, you pay less in taxes, and you take home more pay.

Changes in Plan Elections on a Pre-Tax Basis

This Plan is part of The National Mutual Insurance Company's Section 125 flexible benefits plan. This means that, in most cases, you cannot change the pre-tax salary reduction elections you make when you are first hired or for a subsequent year until the next annual enrollment period, unless you incur a change in family status. A change in family status includes:

- marriage.
- divorce or legal separation.
- birth or adoption of a child.
- death of a spouse or child.
- loss of a spouse's employment.
- employment of a spouse.
- a call to active military duty and the obtaining of a military leave of absence.
- a change from full-time status to part-time status that affects access to health care coverage.
- a change from active status to an unpaid leave of absence that affects access to health care coverage.
- a spouse's change from full-time status to part-time status that affects access to health care coverage.
- a spouse's change from active status to an unpaid leave of absence that affects access to health care coverage.
- a change in employment status that affects access to health care coverage.
- a spouse's change in employment status that affects access to health care coverage.
- a spouse's plan making a significant reduction in the cost of coverage of your spouse's plan (e.g., your spouse must still enroll in the plan, regardless of the cost, but you may want to switch to your spouse's plan).
- a spouse's change in employment that significantly changes your spouse's or your own health care coverage.
- other such events that The National Mutual Insurance Company determines will permit a change in your health care election under Internal Revenue Service regulations and rulings.

If you experience such a change in status and wish to change your level of coverage, you must submit written notification to the Benefits Department within 31 days of your change in family status. The Plan Administrator reserves the right to require the applicant to submit proof of any change of status at the applicant's expense. The change in coverage generally becomes effective the date of the event. Benefits are subject to the pre-existing condition limitations from the date coverage begins.
If you declined coverage when first hired, you may enroll in this Plan during the annual enrollment period. Coverage comes effective January 1 of the new Plan Year. Benefits are subject to the pre-existing condition limitations from the date coverage begins.

OPEN ENROLLMENT

Open enrollment will occur from October 15th to November 1st, with coverage becoming effective on January 1st. Open enrollment is available to Employees who initially did not enroll in the health care plan and for Employees and/or Dependents who did not enroll at the time that a special enrollment occurred. During open enrollment, Employees have the option of selecting a different group health plan.

WAITING PERIOD

All active, full-time, regular, non-exempt Employees are eligible to participate in this Plan after they have completed 30 days of continuous employment from their date of hire. Coverage begins on the 31st day of continuous employment, provided the Employee has submitted a completed enrollment form to the Benefits Department within 31 days of that date.

If you are absent due to any health status factor, or any other reason that must be treated as active service under any applicable law (such as FMLA, ADA or laws relating to military service, or a paid jury duty), such time will not be considered an absence for purposes of measuring your consecutive days of continuous active employment.

If you incur any expenses for an injury or sickness, including a mental, psychoneurotic or personality disorder before the date you or your Dependent is covered, that condition will be considered a Pre-Existing Condition.

SPECIAL ENROLLMENT RIGHTS

Person Who Loses Other Coverage

If you refused coverage for yourself or your Dependents during your initial eligibility period, you will be allowed to enroll yourself and your Dependents for coverage as timely enrollees if all of the following conditions are met:

- You or the Dependent were covered under a different group health plan or health insurance coverage at the time coverage was previously offered;

- You stated in writing that the reason for declining coverage was coverage under a different group health plan or insurance policy;

- The coverage was terminated because of loss of eligibility (including legal separation, divorce, death, termination of employment, reduction in the number of hours of employment), or the employer's contribution towards such coverage was terminated, or the individual exhausted their coverage under COBRA; and

- You request enrollment in the Plan no later than 31 days after losing coverage as a result of loss of eligibility, COBRA exhaustion, or the termination of the employer's contributions.

If you enroll on a timely basis, the effective date of coverage under this Plan will be the date of the loss of other coverage.
Note that even if your Spouse’s employer terminates its contribution to your Spouse’s Plan, your Spouse is still not eligible for this Plan unless your Spouse enrolls in his or her own employer’s Plan. You and your dependents may drop out of your Spouse’s employer’s plan in that event, and enroll in this Plan, even if it is mid-year.

**Acquisition of Dependent Beneficiaries**

If you are eligible for coverage, but failed to enroll previously, you can enroll yourself and your eligible Dependents as timely enrollees if all of the following conditions are met:

- The Plan makes coverage available to Dependents of Employees;
- You are not enrolled in the Plan but have met any waiting period requirement under the Plan and are eligible, but failed to enroll during the previous enrollment period;
- A Spouse or a child becomes your Dependent through marriage, birth, adoption or placement for adoption;
- You request enrollment for yourself and/or your Spouse and/or the child(ren) acquired through the marriage, birth, adoption or placement for adoption within 31 days of the event; and

In addition, you may enroll dependents if you request enrollment in the Plan no later than 60 days after the termination of coverage from Medicaid or Children’s Health Insurance Coverage (CHIP) due to loss of eligibility.

If you enroll on a timely basis, the effective date of coverage under this Plan will be the date of marriage, birth, adoption, placement for adoption, or date of the loss of other coverage.

**PRE-EXISTING CONDITION EXCLUSION PROVISION**

If you have a condition (whether physical or mental) for which medical advice, diagnosis, care or treatment (including prescription drugs) was recommended by or received from a licensed Health Care Provider within six months of your hire date (defined below), you will be subject to a pre-existing condition exclusion. A pre-existing condition exclusion is the amount of time when care related to that condition will not be covered. The exclusion period from the date employment begins with The National Mutual Insurance Company will be 12 months for timely entrants (individuals who enroll when first eligible or at the time of a “Special Enrollment” event, as defined). There will be an 18-month pre-existing condition exclusion period for late entrants. The pre-existing condition exclusion will not apply to: (a) any child under the age of 19; or (b) pregnancy. Genetic information is not an indicator of a pre-existing condition if there is not a diagnosis of a condition related to the genetic information.

The pre-existing exclusion period may be reduced by the number of days you were covered under a Prior Health Plan, unless you have a significant break in coverage. A significant break is 63 consecutive days, during which you have no creditable coverage, excluding any waiting or affiliation period. You have the right to demonstrate coverage under a Prior Health Plan. To do this, you may request a Certificate of Creditable Coverage from a Prior Health Plan or insurer, and provide it to your current Plan Administrator. If necessary, the Plan Administrator will assist you in obtaining a Certificate of Creditable Coverage. If, after due efforts, it becomes apparent that a Certificate of Creditable Coverage is unavailable, the Plan will take into account relevant facts and circumstances to determine whether that individual has Creditable Coverage.
When coverage for you or any of your Dependents terminates under this Plan, your Employer will issue a Certificate of Creditable Coverage. You can also request a Certificate of Creditable Coverage within 24 months after coverage terminates by contacting your Employer.

PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization (PPO) is a group of Hospitals, Physicians, and other Health Care Providers who have agreed to work with an organization to help control health care costs by negotiating reduced fees. The PPO helps employers contain the skyrocketing cost of providing health benefits. The PPO encourages Covered Persons to be cost-minded and become "Partners in Health Care". By using more cost-effective Preferred Providers, you will help stabilize health care coverage costs both to you and to your benefit plan. The PPO also protects your freedom to choose any Physician or Hospital you desire. Alternatives to the PPO include reducing your benefits and increasing your cost. The PPO is a much more attractive solution. The PPO will save you money. The PPO providers have agreed to charge cost-effective rates. You can use any Physician and any health care facility that qualifies under your health plan the same as you have in the past. You make the choice of using or not using a Preferred Provider each time you require services.

OHIO

Medical Mutual (Supermed)  Phone: 1-800-493-2583 
Website: www.medmutual.com

INDIANA

PHCS  Phone: 1-800-530-0621 
Website: www.phcs.com

KENTUCKY

PHCS  Phone: 1-800-530-0621 
Website: www.phcs.com

ALL OTHERS

FIRST HEALTH  Phone: 1-888-685-7774  
Website: www.firsthealth.com

PHCS  Phone: 1-800-530-0621  
Website: www.phcs.com

You may also view and print a copy of the provider directory by visiting the website listed above. You may request a printed copy of the provider directory by contacting the PPO phone number listed above. There is no charge for the directory.
SCHEDULE OF BENEFITS  
COMPREHENSIVE MAJOR MEDICAL BENEFITS

Precertification Review: Precertification review is required for all inpatient Hospital Confinements. For elective stays, certification is required at least 24 business hours prior to admission. For emergency admissions, certification is required within 48 business hours following admission.

If preadmission Hospital certification is not utilized, your benefits under the plan will be reduced by $200.00.

All benefits will be based upon “Reasonable & Customary,” (R&C) allowances.

<table>
<thead>
<tr>
<th></th>
<th>HRA Option 1</th>
<th>HRA Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum on Benefits Payable per Individual</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Network Only (PPO Providers):

Calendar Year Deductible:

<table>
<thead>
<tr>
<th></th>
<th>Per Individual</th>
<th>Per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per individual</td>
<td>$1,000.00</td>
<td>$2,000.00</td>
</tr>
<tr>
<td>Per Family</td>
<td>$2,000.00</td>
<td>$4,000.00</td>
</tr>
</tbody>
</table>

Deductible to be met in the following manner:

First:

Employee Deductible

<table>
<thead>
<tr>
<th></th>
<th>Per Individual</th>
<th>Per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Individual</td>
<td>$250.00</td>
<td>$250.00</td>
</tr>
<tr>
<td>Per Family</td>
<td>$500.00</td>
<td>$500.00</td>
</tr>
</tbody>
</table>

Then:

HRA Bridge:

<table>
<thead>
<tr>
<th></th>
<th>Per Individual</th>
<th>Per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Individual</td>
<td>$500.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>Per Family</td>
<td>$1,000.00</td>
<td>$1,000.00</td>
</tr>
</tbody>
</table>

Then:

Employee Deductible

<table>
<thead>
<tr>
<th></th>
<th>Per Individual</th>
<th>Per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Individual</td>
<td>$250.00</td>
<td>$1,250.00</td>
</tr>
<tr>
<td>Per Family</td>
<td>$500.00</td>
<td>$2,500.00</td>
</tr>
</tbody>
</table>

Network (PPO Providers):

Then: All eligible Network charges will be paid at 80% until the maximum out-of-pocket amount has been satisfied.

With: 100% payment on eligible charges thereafter for that individual for the remainder of that Calendar Year unless otherwise specified.

Note: Exceptions are listed under Comprehensive Major Medical Benefits in the Out of Pocket Maximums.

Maximum Out-of-Pocket Expense per Calendar Year (including the deductible):

<table>
<thead>
<tr>
<th></th>
<th>Per Individual</th>
<th>Per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per individual</td>
<td>$2,500.00</td>
<td>$3,500.00</td>
</tr>
<tr>
<td>Per Family</td>
<td>$5,000.00</td>
<td>$7,000.00</td>
</tr>
</tbody>
</table>

Only $500.00 of the HRA contribution can be used per participant.
The National Mutual Insurance Company  

Group HRA Health Plan

Note: All HRA monies left at the end of the Plan Year from the annual HRA contribution may be carried over from year to year up to a maximum amount of two times the annual HRA benefit. Qualifying expenses that are incurred late in the Plan Year for which reimbursement is sought after the end of such Plan Year will be paid first before any amount is rolled over. Each eligible Participant may use up to a maximum of $1,000.00 of the HRA account after the first year.

Non-Network Only (Non-PPO Providers):

<table>
<thead>
<tr>
<th>HRA Option 1</th>
<th>HRA Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible:</td>
<td></td>
</tr>
<tr>
<td>Per Individual</td>
<td>Per Individual</td>
</tr>
<tr>
<td>Per Family</td>
<td>Per Family</td>
</tr>
</tbody>
</table>

Then: All eligible Non-Network charges will be paid at 60% until the maximum out-of-pocket amount has been satisfied.

With: 100% payment on eligible charges thereafter for that individual for the remainder of that Calendar Year unless otherwise specified.

Note: Exceptions are listed under Comprehensive Major Medical Benefits in the Out of Pocket Maximums.

Maximum Out-of-Pocket Expense per Calendar Year (including the Deductible):

| Per Individual | Per Individual | $5,000.00 | $7,000.00 |
| Per Family | Per Family | $10,000.00 | $14,000.00 |

The Network and Non-Network deductibles, copayments, and out-of-pocket limits are separate and do not accumulate toward each other.
## COVERED SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Payable</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Maximum Daily Semi-Private Room Charge</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Private Room Rate (The Hospital's average semi-private room rate)</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Special Care Unit (ICU &amp; CCU)</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Maximum: 15 counseling visits per family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Miscellaneous Charges</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Inpatient Consultations</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Preadmission Testing (Deductible does not apply)</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Hospital Physician Visits</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Surgical Expense Benefits</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Second Surgical Opinion (Deductible does not apply)</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Maternity Benefits</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Inpatient Newborn Exam (Subject to mother's deductible)</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Nursery (Subject to mother's deductible)</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Birthing Center/Outpatient Delivery</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Accident/Illness (Subject to Safety Measures Provision)</td>
<td>80%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Network Percentage</td>
<td>Non-Network Percentage</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Allergy Testing &amp; Injections</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Wellness Benefit (for all eligible participants of the Plan)</td>
<td>100% of first $750.00 per Calendar year then first deductible then HRA, then deductible, then 80%</td>
<td>100% of first $250.00 per Calendar year then deductible then 60%</td>
<td></td>
</tr>
<tr>
<td>Routine Colonoscopy (Deductible does not apply)</td>
<td>80%</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>(Not subject to the $750.00 wellness benefit maximum)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Baby/Well Child Benefits (birth to the age of 3)</td>
<td>100% of first $750.00 per Calendar year then first deductible then HRA, then deductible, then 80%</td>
<td>100% of first $250.00 per Calendar year then deductible then 60%</td>
<td></td>
</tr>
<tr>
<td>Immunizations (for all eligible participants)</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>(Not subject to the $750.00 wellness benefit maximum)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapy Services</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>(Includes Medically Necessary radiation therapy, chemotherapy, dialysis, vision and hearing therapy, speech therapy, and occupational therapy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>(Precertification is encouraged if more than 2 weeks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Treatment (Age 12 and over)</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td>80%</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

Calendar Year Maximum: 120 days
<table>
<thead>
<tr>
<th>Service</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Private Duty Nursing</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Calendar Year Maximum: 100 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Transplants</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Sleep Disorder Clinic (Requires prior approval)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Mental Nervous Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Alcohol &amp; Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Until such time as regulations are issued by appropriate federal agencies, the Plan will use good faith efforts to define and interpret the term "essential health benefits" in a reasonable and consistent manner to comply with the restrictions against lifetime and annual limits under the federal health care reform law – PPACA.
PPO PROVISIONS

In the following situations, services rendered by a Non-Network provider will be considered at the Network level:

- Ancillary providers rendering care in a PPO facility (i.e.: pathologist, radiologist, anesthesiologist, emergency room physician);
- If a Covered Person has no choice of network providers in the specialty that the Covered Person is seeking within the PPO service area;
- If a Covered Person is out of the PPO and requires medical care;
- When a PPO provider utilizes the services of a Non-PPO provider for the reading or interpretation of x-ray or laboratory tests;
- If a Covered Person does not live within 25 mileage radius of a PPO facility;
- Eligible Dependent Children who reside outside of Primary PPO service area.

However, in these instances, the individual may be responsible for charges in excess of the Reasonable and Customary amount. Please call the Claims Administrator if you believe any of these provisions apply to you.

PRESCRIPTION DRUG BENEFITS

Retail Copay:
- Generic .................................................................................................................. $15.00
- Formulary ............................................................................................................. $30.00
- Non-Formulary ..................................................................................................... $45.00

Mail Order Copay:
- Generic .................................................................................................................. $30.00
- Formulary ............................................................................................................. $60.00
- Non-Formulary ..................................................................................................... $90.00

Mandatory Generic Provision – The patient is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand name drug. The patient payment is the price difference between the brand drug and generic drug in addition to the generic drug copayment.
The National Mutual Insurance Company

Group HRA Health Plan

PRECERTIFICATION OF BENEFITS

PREVIEW MANAGED CARE PROGRAM

The PReview managed care program is administered by the PReview Utilization Management Department of Medical Mutual. The program is designed to reduce unnecessary hospital admissions and to ensure that health care services are delivered in the most cost efficient manner keeping quality, as well as cost, in mind. The program also provides a means of getting answers to your health care questions and to study alternatives to a hospital stay. To assure that services are medically necessary and that care is delivered in the most appropriate setting, the following are required:

- Preadmission Certification
- Concurrent Review and Recertification
- Retrospective Review
- Individual Case Management

Inpatient admissions to a Hospital must be pre-certified. The phone number is listed on your identification card. Contracting Hospitals in Ohio will assure this precertification is done; and since these Hospitals are responsible for obtaining the precertification, there is no penalty to you if this is not done. For Non-Contracting or Out of State Hospitals, you are responsible for obtaining precertification.

If you do not pre-certify a Hospital admission and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for the billed charges. However, if your Inpatient stay is for an organ transplant, please review the requirements under the Transplant section.

NOTIFICATION OF HOSPITAL ADMISSION for Non-Contracting or Out of State Hospitals

Elective Admissions

An elective Hospital admission refers to a pre-planned admission to the Hospital for an overnight stay or longer. Patients are required to give notice to Medical Mutual of all elective admissions, except pregnancies, prior to admission.

Emergency Admissions

An emergency/urgent admission refers to a situation that requires immediate Hospitalization. In such case, the patient must call Medical Mutual within 48 business hours of admission and provide them with the pertinent information concerning the admission.

Medical-Surgical Phone: (800) 338-4114
Behavioral Health Phone: (800) 258-3186
COMPREHENSIVE MAJOR MEDICAL BENEFITS

BENEFITS PAYABLE

If you or a Dependent incur covered expenses after the effective date of your major medical coverage, payment will be made, at the appropriate Coinsurance level, for expenses Incurred during a Calendar Year which exceed the deductible (and any applicable Copay amounts) as listed in the Schedule of Benefits. These percentages apply until the Covered Person reaches the maximum out-of-pocket amount, then eligible expenses will be payable at 100% of the Reasonable and Customary charge, unless otherwise specified.

COINSURANCE

Coinsurance is the amount you must pay for each service when the Plan pays benefits, typically after the deductible is satisfied and before the out-of-pocket maximum is reached. This is a percentage of the eligible benefit that is not covered by the Plan. For example, for those benefits for which the Plan pays 80%, you are responsible for the 20% coinsurance.

COPAYMENT

A copayment is a flat amount which you must pay for certain services before the Plan pays benefits. For example, for generic mail order prescription drugs, you must first make a copayment, and the Plan then covers the remainder of your eligible expenses for those services at 100%.

DEDUCTIBLE

The deductible will be applied only once during a Calendar Year.

Common Accident Deductible

If two or more Covered Persons of a family are injured in the same accident, only one deductible will be applied toward those eligible expenses, which directly resulted from injuries Incurred by family members in the same accident.

OUT-OF-POCKET MAXIMUM

The out-of-pocket amount applies each Calendar Year. Benefits will be payable at the appropriate Coinsurance level, subject to Reasonable and Customary, until you have paid the out-of-pocket amount as listed in the Schedule of Benefits. (The out-of-pocket amount includes the deductible amount). Then benefits will be payable at 100% of Reasonable and Customary. The out-of-pocket maximum does not include:

- Charges in excess of the R&C
- Charges (penalties) incurred for non-compliance with the Pre-Certification
- Charges (penalties) incurred for non-compliance with the Safety Measures Provision
- Co-payments for prescription drugs
- Charges as coinsurance for bereavement counseling (as part of hospice care services)
- Items listed in the Exclusions and Limitations - Medical section
METHOD OF PAYMENT

Your Benefit Plan uses a Reasonable and Customary (R&C) fee method of payment for Covered Services. These Covered Services will be paid at a rate that is equal to or lower than the R&C level.

- Reasonable: The charge considered reasonable for medical circumstances or complications requiring additional time, skill or experience in connection with a particular case.

- Customary: Charges of Physicians generally of similar training and experience in that geographical area for same or similar services.

SAFETY MEASURES PROVISION

If you or a covered Dependent incurs covered charges for an injury sustained in an automobile (to include car, truck, van, and the like) accident, an additional deductible of $500.00 will be applied if the Plan participant was not wearing a safety belt or similar restraint at the time of the accident. This provision also applies to children who are required to be in safety restraints or car seats.

If you or a covered Dependent incurs an injury sustained while operating (or riding on) a motorcycle, moped, motorized scooter, all-terrain vehicle (ATV), three-wheeler, or trail bike, an additional deductible of $500.00 will be applied if the Plan participant was not wearing an appropriate helmet at the time of the accident.

In either case, the additional $500.00 deductible (penalty) cannot be used to satisfy the out-of-pocket maximum.
COVERED SERVICES

The following are Covered Services, payable as outlined in the Schedule of Benefits, and subject to the other terms, conditions and limitations described in this booklet.

HOSPITAL SERVICES

When you or your Dependent is admitted as a bed patient or as an outpatient to any state approved Hospital, the following services will be covered as needed and to the extent available for:

Inpatient Hospital Services - bed, board, and general nursing services:

- A room with two or more beds;
- A private room. The private room allowance is the Hospital's average semi-private room rate;
- A bed in a special care unit approved by the Plan. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients; and
- Miscellaneous Hospital expenses for a physical Injury or Illness received by a Covered Person while the Covered Person is Confined in a Hospital.

Ancillary Services - Inpatient and Outpatient; include but are not limited to:

- Allergy care (extract and injection);
- Allergy tests;
- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs;
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or Other Provider;
- Medical and surgical dressings, supplies, casts and splints;
- Rehabilitative services;
- Diagnostic services; and
- Physiotherapy, hydrotherapy, and other therapy services.

Blood and Blood Plasma

Whole blood, blood plasma, and blood products when not replaced by donation are eligible to a maximum of $25.00 per pint. This includes the processing and administration of services.

Outpatient Hospital Services

- **Diagnostic:** Lab and x-ray services.
- **Emergency Accident Care:** Services and supplies to treat injuries caused by an accident within 48 hours of the accident;
- **Emergency Illness Care:** Services and supplies to treat a sudden and acute medical condition that is life threatening and require prompt medical care. Examples of covered conditions are heart attacks, kidney stones, and strokes;
- **Operating room and supplies:**
- **Preadmission Testing:** Outpatient tests and studies performed within 10 days prior to a scheduled Hospital admission. Benefits are payable as shown in the Schedule of Benefits;
- **Surgery:** Surgical services and supplies.
MEDICAL-SURGICAL BENEFITS

In general, the Plan will pay for eligible charges for services that include the following:

ALCOHOL & SUBSTANCE ABUSE BENEFITS

Inpatient and Day Treatment Benefits

The charges for inpatient services are payable as listed in the Schedule of Benefits.

Benefits are provided for inpatient and partial Hospitalization, and day treatment substance abuse care only at a licensed facility. Inpatient services must be pre-certified before admission, and the Medical Necessity of treatment must be determined before coverage is approved.

Residential care rendered by a Residential Treatment Facility is not covered.

Outpatient Benefits

The charges for outpatient services are payable as listed in the Schedule of Benefits.

Benefits are provided for outpatient psychiatric care by a licensed Psychologist, Psychiatrist, or Licensed Social Worker. These services require that a treatment plan be submitted to and approved by the Plan after the initial assessment. Each patient will be allowed up to 3 visits before determination of Medical Necessity. Coverage of additional visits will be determined based on the Medical Necessity of the treatment.

AMBULANCE SERVICE

Transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- From the Covered Person's home, scene of accident or medical emergency to a Hospital;
- Between Hospitals;
- Between Hospital and Skilled Nursing Facility;
- From a Hospital or Skilled Nursing Facility to the Covered Person's home.

Trips must be to the closest facility that can provide Covered Services appropriate for the Covered Person's condition. If none, coverage is available for trips to the closest such facility outside the Covered Person's local area. Railroad or air ambulance service to the nearest Hospital qualified to provide the necessary treatment is covered under the Plan when Medically Necessary.

Transportation services provided by an ambulette or wheelchair van are not Covered Services.

ANESTHESIA

Benefits are provided for the administration of spinal, rectal, or local anesthesia, or a drug or other anesthetic agent by injection or inhalation. Benefits are also payable for services rendered by a Certified Registered Nurse Anesthetist (CRNA). Some anesthesiologists are not considered in-network providers. Many anesthesiologists are independent contractors and not Hospital employees.
BEREAVEMENT COUNSELING

The Plan will cover bereavement counseling for a covered person within 6 months of a family member's death, subject to maximums as shown in the Schedule of Benefits.

CARE OUTSIDE THE UNITED STATES

Benefits equivalent to those in Hospitals in the United States are provided to Employees and their covered Dependents in the event of an emergency while traveling or vacationing outside the United States. You should pay the provider and then submit the bill to the Claims Administrator for reimbursement. Only emergency illnesses and accidental injuries are covered when care is provided by a Physician and/or a Hospital outside the United States. Any hospitalization requires the pre-certification steps to be completed.

Employees (and their covered Dependents) residing outside the United States, and covered Dependents with commitments outside the United States which are approved by the Plan Administrator, are eligible for benefits for medical coverage and Hospital services equivalent to those provided to Plan participants within the United States. When obtaining services outside the United States, the Plan participant is encouraged to obtain a pre-certification of benefits before receiving services from the Physician and/or Hospital. Benefits are provided only for services rendered by facilities that meet the standards of their localities comparable to those established by the American Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or for services rendered by Physicians meeting the credentials of their localities comparable to the credentials of Board Certification from the American Medical Association (AMA). Benefits are not provided for any services considered experimental or investigational.

CONCURRENT MEDICAL CARE

Benefits are provided for services rendered concurrently by a Physician other than the attending Physician when warranted by the need for the skills of a specialist. A patient is eligible for concurrent medical care if he or she has a separate and complicated diagnosis, which, if left untreated, would adversely affect his or her prognosis, and if management of the condition requires the skills of a specialist.

CONSULTATION

A personal bedside examination by another Physician when requested by the Covered Person's attending Physician. Staff consultations required by Hospital rules are excluded.

DENTAL SERVICES FOR ACCIDENTAL INJURY

The Plan will cover accidental Injury to the jaw, sound natural teeth (including their replacement), mouth, or face if the treatment is given within one year after the date of Injury. Treatment beyond this one-year period may be provided if documented as medically necessary. An Injury caused by chewing or biting is not considered an accidental Injury. Benefits are not provided for dentures or fixed bridges required as a result of accidental Injury to the jaw or sound natural teeth.

Oral Surgery

Benefits are provided for the removal of full bony impactions, including wisdom teeth, and the removal of tumors or cysts to the mouth.
DIAGNOSTIC SERVICES

The following services when performed for diagnosis of a condition, disease, or injury and the Physician's interpretation of these exams are covered under your plan:

- Radiology, ultrasound and nuclear medicine;
- Laboratory and Pathology Services;
- Diagnostic Medical Examinations such as EKG's and EEG's, MRI's;
- Cardiographic, Encephalographic and Radioisotope Tests;
- Allergy Testing.

Diagnostic services may be provided either in or out of a Hospital.

EMERGENCY ROOM SERVICES

Benefits are provided for:

- Treatment of an emergency illness; services and supplies to treat a sudden and acute medical condition that is life threatening and require prompt medical care. Examples of covered conditions are heart attacks, kidney stones, and strokes;
- The initial treatment of an accidental injury; services and supplies to treat injuries caused by an accident within 48 hours of the accident;

Benefits are also provided for the Physician's charges for surgical or medical care required as a result of an accidental injury or emergency illness.

HOME HEALTH CARE SERVICES

This section applies only if charges for home care services are not covered elsewhere in the Plan. A licensed or Medicare-certified home health agency or certified rehabilitation agency must provide or coordinate the services. A Covered Person should make sure the agency meets this requirement before services are provided. These medical services and supplies are covered to the extent that such charges would have been considered covered charges had a person required confinement in the Hospital as a registered bed patient, or confinement in a Skilled Nursing Facility. The Plan will pay benefits for charges for the following services:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
- Part-time or intermittent home health aide services when part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;
- Physical or occupational therapy or speech-language pathology or respiratory care;
- Medical supplies, drugs, and medications prescribed by a Physician; laboratory services by or on behalf of a Hospital is needed under the home care plan. These items are covered to the extent they would be if the Covered Person had been hospitalized;
- Nutrition counseling provided or supervised by a registered dietician; and
- Evaluation of the need for a home care plan by a registered nurse, Physician extender, or medical social worker. The Covered Person's attending Physician must request or approve this evaluation.
• Home care is not covered unless the Covered Person's attending Physician certifies that (a) Hospitalization or Confinement in a licensed Skilled Nursing Facility would be needed if the Covered Person didn't have home care; and (b) members of the Covered Person's immediate family, or others living with the Covered Person couldn't give the Covered Person the care and treatment he/she needs without undue hardship.

• If the Covered Person was Hospitalized just before home care started, the Covered Person's primary Physician during his/her Hospital stay must also approve the home care plan.

• Each visit by a person providing services under a home care plan, evaluating the Covered Person's need or developing a plan counts as one visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.

In order to continue home health services, re-certification by the Physician to the Claims Administrator of the continued need for care is required after the first 30 days and must be provided every 30 days thereafter.

HOSPICE BENEFITS

Hospice services consist of health care services provided to a terminally ill Covered Person. Hospice services must be provided through a Hospice Facility or a Hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

Benefits for Hospice services are available when the prognosis of life expectancy is six months or less. Benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy. The following services and supplies are eligible:

• Professional services of a registered or licensed practical nurse;
• Treatment by physical means, occupational therapy, and speech therapy;
• Medical and surgical supplies;
• Prescription drugs; (these prescription drugs must be required in order to relieve the symptoms of a condition, or to provide supportive care);
• Oxygen and its administration;
• Medical social services, such as the counseling of patients;
• Home health aide visits;
• Acute inpatient Hospice services;
• Respite care;
• Dietary guidance; counseling and training needed for a proper dietary program;
• Durable Medical Equipment; and
• Bereavement counseling for a covered person within 6 months of a family member's death, subject to a maximum of 15 counseling visits per family.

A treatment plan must be developed and submitted to the Plan by the Covered Person's Physician and the Provider of the Hospice services. The treatment plan must be approved by the Plan.

Non-covered Hospice services include, but are not limited to:

• Volunteer services;
• Spiritual counseling;
• Homemaker services;
• Food or home delivered meals;
• Custodial Care, rest care or care which is provided solely for someone's convenience.

**HUMAN ORGAN AND TISSUE TRANSPLANTS**

This health plan document includes a special attachment regarding human organ and tissue benefits, as explained in full in the Organ & Tissue Transplant Policy. All eligible employees and their Dependents requiring human organ and tissue transplant services will have transplant-related charges covered under this separate policy, according to its terms and conditions, from the time of their evaluation through 365 days post transplant operation. After this specified benefit period elapsed, all transplant-related medical benefits will revert to the terms and conditions of health coverage under this health plan document.

Benefits available for Human Organ and Tissue Transplants are subject to the following:

a. The Employee and Dependent(s) are eligible for medical benefits under the group's health plan document.

b. The Employee and Dependent(s) meet all the terms and conditions outlined in the Organ and Tissue policy/certificate

c. The Employee or Dependent(s) do not have a pre-existing condition as defined in the Organ and Tissue policy/certificate

Those Employees and their Dependents who are initially excluded from human organ and tissue transplant coverage under the Organ & Tissue Transplant policy (due to a pre-existing condition) will continue to receive health care benefits as they relate to transplantation according to the terms and conditions of the company health plan document and until eligible for benefits under the separate policy.

**INPATIENT HOSPITAL MEDICAL CARE**

Benefits are provided for professional services rendered by the attending Physician while the Plan participant is hospitalized. The Plan pays benefits for Plan participants who receive medical services beginning on the first day of such hospitalization.

**MASTECTOMY**

In compliance with the Women's Health and Cancer Rights Act of 1998, the following benefits are available to a Covered Person who elects breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance, however, coverage is not provided for removal of a healthy breast for preventative or reconstructive purposes;
- Coverage for prostheses and physical complications of all stages of mastectomy including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Such coverage will be subject to annual deductibles and Coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan or coverage.
MATERNITY (Statement of Rights under the Newborns' and Mothers' Health Protection Act)

Your Plan covers obstetrical care including prenatal and postnatal care for all eligible Employees and all eligible Dependents when covered under a family contract. A child becomes a covered Dependent at birth, provided the child is enrolled in the Plan within 31 days of the date of birth. Coverage will be paid as shown in the Schedule of Benefits.

Benefits are provided for obstetrical services rendered by the Physician in charge of the case, including services customarily rendered as prenatal and postnatal care. Benefits are also payable for prenatal care, delivery services, and postnatal care rendered by a Certified Nurse Midwife (CNM). Benefits for obstetrical services are provided to the Employee and covered Dependents.

Under Federal law, group health plans and health insurance issuers offering group health coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your Physician, nurse, midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under Federal law, require that a Physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Therefore, if your Plan contains a precertification requirement, you or your Provider must still pre-certify the stay to avoid any additional out-of-pocket expenses; however, your stay will automatically be pre-certified for 48 or 96 hours as required by this Federal law.

Abortion

Benefits are provided for therapeutic abortion for the Employee and the Employee's Spouse if the life of the mother is in danger. Voluntary abortion procedures are NOT covered under the Plan.

Birthing Center

Treatment in a licensed Birthing Center, which meets all of the criteria, is also eligible:

- It is primarily engaged in providing birthing services for low risk pregnancies;
- It is operated under the supervision of a Physician;
- It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;
- It has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.
Newborn Exam
Inpatient visits to examine a newborn, including circumcision. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Surgical Sterilizations
Regardless of Medical Necessity, surgical sterilization procedures for either a covered Employee or an Employee's covered Spouse are provided under the Plan. Reversal of sterilization is not a Covered Service.

MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES
The Plan will allow a maximum of 150% markup on invoice and may require a copy of the Provider's invoice prior to payment.

Medical and Surgical Supplies
Syringes, needles, oxygen, casts, surgical dressings, trusses, braces (other than dental braces), crutches, splints and other similar items which serve only a medical purpose. These supplies prescribed by your Physician: catheters, colostomy bags, rings and belts, flotation pads, needles and syringes, and initial contact lenses or eyeglasses after cataract surgery will also be eligible for coverage. Covered services do not include items usually stocked in the home for general use like adhesive bandages, thermometers, and petroleum jelly.

Durable Medical Equipment
Rental of, or at the Plan's option, purchase of Durable Medical Equipment such as, but not limited to: wheel chairs; Hospital-type beds; and artificial respiration equipment. Rental costs must not be more than the purchase price. When the equipment is purchased, benefits are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance and replacement of batteries are not covered. The equipment must be prescribed by the Physician. It must serve only a medical purpose and be able to withstand repeated use. Benefits are payable only if the Plan approves the equipment as being appropriate for a Covered Person's medical condition.

Note: The Plan will allow for only the standard equipment necessary, additional options and upgrades are not eligible.

Orthotic Devices
A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part, such as: casts, splints; strapping; orthopedic braces; and crutches.

Orthotic must be custom molded and prescribed by a Physician and not used only to improve comfort or appearance.

These do not include special shoes unless the device is a permanent part of an orthopedic brace.
Prosthetic Appliances
Purchase, fitting, needed adjustment and necessary repairs of prosthetic devices, replacement of prosthetic devices and supplies that replace all or part of a missing body organ and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ.

- Pre-certification is encouraged for these services
- The Plan covers charges for contact lenses following cataract surgery
- The Plan covers charges for orthopedic inserts and their fitting as prescribed by a Physician as being Medically Necessary
- The Plan covers charges for penile implants if required due to an organic condition

This benefit will also include replacements for children who, due to growth, must obtain a new prosthetic appliance.

MENTAL HEALTH BENEFITS
Benefits are provided as listed in the Schedule of Benefits for inpatient and partial Hospitalization, and Day Treatment Psychiatric Care only at a licensed facility. Inpatient services must be pre-certified before admission, and the Medical Necessity of treatment must be determined before coverage is approved.

Benefits are provided for outpatient psychiatric care by a Licensed Psychologist, Psychiatrist, or Licensed Social Worker, including services provided in a Day Treatment Program as listed in the Schedule of Benefits.

MISCELLANEOUS COVERED CHARGES
The Plan will cover the following: The removal of impacted teeth, injectable insulin syringes, optic training, oxygen, only for medical purposes, and an oxygen concentrator, when deemed by the Plan to be Medically Necessary and removal of tumors or cysts of the mouth.

OUTPATIENT DIAGNOSTIC SERVICES
The Plan covers the following diagnostic services (to include radiologist and pathologist fees):

- Basal metabolism tests
- Computerized axial tomography (CAT scan)
- Electrocardiograms (EKG)
- Electroencephalograms (EEG)
- Electromyography
- Intravenous therapy
- Magnetic resonance imaging (MRI)
- Outpatient diagnostic and laboratory examinations, as well as X-ray examinations
- Pulmonary function tests
- Venous Doppler studies
- Venipuncture

These tests are covered when the study is directed toward the diagnosis of a definite condition, disease, or injury.
OUTPATIENT MEDICAL CARE

Office visits and consultations to examine, diagnose, and treat an eligible condition.

PHYSICIAN’S FEES FOR OUTPATIENT DIAGNOSTIC X-RAY AND LAB

Benefits are provided for diagnostic X-ray, laboratory, and pathological services given in a Physician’s office which are required for the diagnosis of any condition, disease, or injury, and that are customarily billed by the Physician who made such examination.

PRIVATE DUTY NURSING SERVICES

Services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) when ordered by a Physician will be covered as follows: Nursing services do not include care that is primarily non-medical or custodial in nature such as bathing, exercising and feeding.

Benefits are not provided for a nurse who usually lives in your home nor is a member of your immediate family.

Inpatient Services

Services that are of such nature or degree of complexity that the Provider's regular nursing staff cannot provide them or due to the Hospital's Intensive Care Unit being full. Prior approval is required.

PROFESSIONAL INTERPRETATION SERVICES INPATIENT AND OUTPATIENT

Benefits are provided for the interpretation of diagnostic tests.

RETAIL PRESCRIPTION DRUG PROGRAM

This Plan provides benefits for prescription drugs ordered in writing by a Physician for treatment incurred because of an accidental injury or illness, or as a result of pregnancy, childbirth, or a related medical condition. Benefits are paid according to the Schedule of Benefits. Any copayments which you make will not apply toward this Plan's annual out-of-pocket maximum. The mail order copays are not eligible under the Major Medical reimbursement

SKILLED NURSING FACILITY/REHABILITATION FACILITY BENEFITS

Benefits are available for Covered Services in a Skilled Nursing Facility / Rehabilitation Facility as listed in the Schedule of Benefits. No coverage is provided for services for Custodial Care; or, care for senile deterioration, mental deficiency, or mental retardation.

Confinement in the facility:

- must begin within two days after the Covered Person has been Confined in a Hospital for which room and board charges were paid; and
- is for treatment of the Illness causing the Hospital Confinement; and
- is one for which a Physician visits the Covered Person at least once every 30 days; and
- is not for routine Custodial Care.
SURGICAL SERVICES

The Plan covers you for surgical services performed by a Physician both in and out of a Hospital. As well as covering most operative and cutting procedures, surgery includes treatment of burns, fractures, and dislocations. It includes surgical pathology examinations, cast, and suture removal. Medical Necessity is not required for sterilization procedures, if performed on an outpatient basis. Surgery must be done by a Physician.

Regardless of Medical Necessity, the Plan covers surgery to restore bodily function or correct deformity. Benefits are only for problems caused by disease, Injury, birth or growth defects, or previous treatments.

Surgical Assistance

An assistant Physician to assist your surgeon while performing covered surgery when a house staff member, intern, or resident cannot be present. Allowable charges cannot exceed 20% of the surgeon's Reasonable and Customary allowance.

Multiple Surgical Procedures

If two or more surgical procedures are performed through the same body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 50% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

If two or more surgical procedures are performed through more than one body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 75% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

Note: Where a PPO discount applies, the percentages will be based on the discounted charges.

Second Surgical Opinion

A voluntary second surgical opinion is recommended for some elective (non-emergency) procedures. The intent of this program is to provide patients with additional information before a decision is made in an attempt to promote the delivery of high quality health care and eliminate unnecessary surgery.

The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the surgery.

NOTE: A third opinion will be covered if the first two conflict.
THERAPY SERVICES

Eligible Hospital and Physician therapy services or supplies used to promote recovery from an Illness or Injury include:

Cardiac Rehabilitation

Phase I and II will be covered benefits; Phase III is not covered.

Phase I begins approximately 2-4 days following a heart attack, or 24 hours post-Surgery. Patients are assisted through range of motion exercises, which gradually progress to walking or stair climbing by the time of discharge.

Phase II is an outpatient, Hospital-based program, usually of 2-3 months duration. Patients engage in a monitored program of exercise therapy, health education and individualized or group support sessions.

Phase III is an outpatient exercise program held at various community fitness facilities. Patients engage in conditioning activities supervised by a Registered Nurse and an exercise physiologist.

Chemotherapy

The treatment of malignant disease by chemical or biological antineoplastic agents.

Outpatient Dialysis

Benefits provided under the Plan for treatment received in connection with Outpatient Dialysis are subject to the following provisions:

The Plan provides an alternative basis for payment of claims associated with dialysis-related services and products provided on an outpatient basis ("Outpatient Dialysis"). This alternative basis is applied to non-contracting providers and, in some circumstances, applied to claims by a provider who has a contract with the Preferred Provider Organization (PPO).

All eligible employees and their dependents requiring Outpatient Dialysis are subject to cost containment review, negotiation and/or other related administrative services which the Plan Administrator may elect to apply in the exercise of the Plan Administrator’s discretion.

The Plan shall pay no more than the Usual and Reasonable Charge for covered services and/or supplies incurred in connection with Outpatient Dialysis, after deduction of all amounts payable by coinsurance or deductibles. The Plan Administrator shall determine the benefits based on the Usual and Reasonable Charge. The Plan Administrator may pay or reimburse charges greater than the Usual and Reasonable Charge based upon factors concerning the nature and severity of the condition being treated, geographic and market considerations and provider availability, in the exercise of the Plan Administrator’s discretion. All charges must be billed in accordance with generally accepted industry standards.

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

Usual and Reasonable Charge shall mean charge(s) based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services
and/or supplies by all types of plans in the same market area during the preceding calendar
year, adjusted for the National Consumer Price Index medical care rate of inflation.

**Hyperbaric and Pulmonary Therapy**

Introduction of high-density solutions into the lungs for treatment purposes. Treatment must be
provided by a Hospital.

**Occupational Therapy**

The treatment of a physically disabled person by means of constructive activities designed and
adapted to promote the restoration of the person's ability to satisfactorily accomplish the
ordinary tasks of daily living and those tasks required by the person's particular occupational
role.

The expectation must exist that the therapy will result in a practical improvement in the level of
functioning within a reasonable period of time. No benefits are provided for diversional,
recreational, and vocational therapies (such as hobbies, arts and crafts). Therapy must be
ordered by a Physician and provided on a regular basis.

**Radiation Therapy**

The treatment of disease by X-ray, radium, or radioactive isotopes.

**Respiratory Therapy**

Treatment by the introduction of dry or moist gases into the lungs, and other respiratory therapy
related services.

**Speech Therapy**

Benefits are provided for speech therapy when services are rendered as active treatment for
improvement or correction of an organic medical condition.

**Spinal Treatment/Chiropractic (non-surgical)**

Detection or non-surgical correction (by manual or mechanical means) of a condition of the
vertebral column including distortion, misalignment or subluxation to relieve the effects of nerve
interference which results from or relates to such conditions of the vertebral column. Please
refer to the Schedule of Benefits pages for Plan limitations.

Benefits for x-rays received in connection with non-surgical spinal treatment are payable in the
same manner as they are for other covered x-rays.

The expectation must exist that the therapy will result in a practical improvement in the level of
functioning within a reasonable period of time. No benefits were provided for diversional,
recreational and vocational therapies (such as hobbies, arts and crafts).

**Therapy by Physical Means**

Treatment given to relieve pain, restore maximum function and prevent disability following
disease, Injury or loss of body part. Services include hydrotherapy; heat or similar modalities;
physical agents; hyperbaric therapy; biomechanical, neurophysiological principles and devices.
Treatment must be Medically Necessary and non-maintenance to be eligible as a Therapy Benefit.

URGENT CARE/WALK-IN CARE

Urgent Care/Walk-in Care will be covered subject to the limitations described in the Schedule of Benefits.

WELLNESS BENEFIT

Each Covered Person is provided an annual Wellness benefit to cover the costs of any combination of the listed preventative health care tests. The following tests are paid according to the Schedule of Benefits:

- Hemoccult Test: once a year
- Mammogram Test: once a year for females
- Pap Test and Exam: once a year
- Prostate Exam: once a year as part of a general rectal exam
- PSA (Prostate Specific Antigen) Test: once a year as part of the prostate rectal exam
- Well Child Care: for children up to 3 years of age
- Colorectal Cancer Screening

Colorectal Cancer Screening will be payable as listed in the schedule of benefits.

1. Colonoscopies are covered every 10 years for individuals age 50 years and older.

2. Colonoscopies are covered every 10 years beginning at age 40 for persons with a single first-degree relative (sibling, parent, or child) diagnosed with either colorectal cancer or adenomatous polyps before 60 years of age.

3. Colonoscopies are covered as frequently as every two years for individuals with one or more of the following high-risk factors for colorectal cancer:
   - A first-degree relative (sibling, parent, child) who has had colorectal cancer or an adenomatous polyposis (screening covered beginning at age 40 years); or
   - Family history of familial adenomatous polyposis (screening covered beginning at puberty); or
   - Family history of hereditary non polyposis colorectal cancer (HNPPCC) (screening covered beginning at age 21 years).

4. Colonoscopies are covered as frequently as every 1 to 2 years for individuals who meet any of the following criteria:
   - Patient has inflammatory bowel disease (including ulcerative colitis or Crohn's disease); or
   - Personal history of adenomatous polyps; or
   - Personal history of colorectal cancer.

Note: Diagnostic testing with FOBT, colonoscopy, sigmoidoscopy, and/or DCBE will be covered when medically necessary for evaluation of patients with signs or symptoms of colorectal cancer or other gastrointestinal diseases.
GENERAL LIMITATIONS AND EXCLUSIONS

The following are not covered by the Benefit Plan:

1. **Abdominal surgery.** Regardless of Medical Necessity, services and/or supplies for abdominal surgery and/or reconstructive surgery which is related but not limited to gastric related bypass surgery, or stomach stapling type surgery will not be eligible. This includes surgical intervention for infections, chaffing, pain, diabetes, etc;

2. **Abortion.** Elective abortions;

3. **Absence of coverage.** Charges which would not have been made had coverage not existed;

4. **Absent.** Services and/or supplies furnished during periods when the patient is temporarily absent from the Hospital;

5. **Accidental Injury.** An injury for which you are reimbursed or entitled to be reimbursed by any other party;

6. **Acupuncture / Acupressure;**

7. **Biofeedback.** Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing;

8. **Blood.** Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient;

9. **Breast Surgery or Services.** Altering the size or shape of the breast, male or female, whether voluntary or not. This exclusion does not apply to reconstructive surgery performed as a result of a mastectomy. This exclusion does not apply to breast reduction surgery if a treatment plan is submitted in advance to the Claims Administrator and the Plan participant has multiple medical conditions that are worsened by the natural size of the breasts;

10. **Charges in excess of the semi-private rate,** except as otherwise noted;

11. **Chelation therapy,** except for treatment of heavy metal poisoning;

12. **Chest X-Rays, routine,** which are not incidental to the treatment of a manifested injury or illness;

13. **Chiropractic Care** for Plan participants under the age of 12, unless a treatment plan has been submitted to and approved by the Plan prior to initiation of treatment;

14. **Civil insurrection or riot.** Treatment or services resulting from participating in a civil insurrection or riot;

15. **Claims** posted to the Claims Administrator after June 30th following the end of the Calendar Year in which the charges were incurred;

16. **Close Relative.** Service provided by a "close relative," meaning Spouse, or Covered Person's or Spouse's parent, brother, sister or child, or the Spouse of the Covered Person's parent, brother, sister or child;
17. **Completion** of claim forms, or missed appointments;

18. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan;

19. **Congenital malformations** (except in the case of a newborn) unless Medically Necessary, as approved by the Plan prior to initiation of treatment;

20. **Contraceptive devices or medication.** Medications, devices or the fitting of devices for birth control purposes;

21. **Corrective Shoes,** except for the prescription to change a part of the shoe for Medically Necessary reasons;

22. **Cosmetic services.** Services rendered for cosmetic purposes, unless made necessary by accidental injury. This includes, but is not limited to stomach stapling, breast augmentation and face lifting;

23. **Court-ordered services,** Charges for health care ordered by the court, (i.e. court ordered rehabilitative treatment or services) unless documented to be Medically Necessary;

24. **Custodial Care.** Services or supplies provided mainly as a rest cure, domiciliary or convalescent care, or Custodial Care;

25. **Dental procedures,** except as specified in the Plan. Charges for appliances or restorations to increase the vertical dimension of the mouth or to restore the occlusion (bite);

26. **Diagnostic Hospital Admission.** Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting;

27. **DNA Testing;**

28. **Eating disorders,** inpatient treatment, and outpatient treatment unless an outpatient treatment plan has been submitted to and approved by the Plan Administrator prior to initiation of treatment;

29. **Educational or vocational testing.** Services for educational or vocational testing or training, except for diabetic management training, peritoneal dialysis, or any other educational service deemed to be Medically Necessary by the Plan;

30. **Excess charges.** Charges that exceed the Reasonable and Customary allowance, if applicable;

31. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy, as specified by this Plan. This exclusion includes exercise equipment;

32. **Experimental or Investigative services, procedures, treatment, prescription drugs and supplies, or substances,** which have not been recognized as accepted standards of medical protocol;
33. **Eye care.** Radial keratotomy or other eye surgery to correct sight, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, and initial cataract lenses after cataract surgery;

34. **Family counseling;**

35. **Felony.** Services and/or supplies for treatment of an accident or Illness that resulted while committing a felony, unless due to a medical condition (physical or mental), this does not include services and/or supplies incurred by a victim of domestic violence;

36. **Fertility drugs;**

37. **Food supplements** or augmentation, any form (unless necessary to sustain life in a critically ill person);

38. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) and routine foot care; Nail trimming, Hygienic and preventative maintenance foot care including but not limited to:
   - Cleaning and soaking of feet
   - Applying skin creams in order to maintain skin tone
   - Other services that are performed when there is not a localized illness, injury or symptom involving the foot.

39. **Genetic counseling or testing.** Counseling or testing concerning inherited (genetic) disorders;

40. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid, to Medicare or when otherwise prohibited by law;

41. **Growth hormone therapy,** unless pre-approved by the Plan Administrator;

42. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;

43. **Hazardous Activities.** Treatment for injuries sustained while hang gliding, bungee jumping, parachuting, riding an ATV (3 or 4 wheeler), or injuries sustained while racing any sort of motorized vehicle;

44. **Hearing Care.** Hearing aids or examinations for prescribing or fitting them;

45. **Hospital Employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service;

46. **Housekeeping, shopping, or meal preparation services** (except as provided through an approved Home Health Care Program, as described in Covered Services in this booklet);

47. **Hypnosis;**
The National Mutual Insurance Company

Group HRA Health Plan

48. Immunotherapy;

49. Impotence. Care, treatment, services, supplies or medication in connection with treatment for impotence not caused by organic disease;

50. Infertility. Reproductive infertility services including but not limited to - family planning; fertility tests; infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance the reproductive ability; premarital examinations; impotence, organic or otherwise;

51. Liposuction;

52. Marital counseling. Treatment, services and supplies for marriage counseling, health education, holistic medicine or other programs with an objective to provide complete personal fulfillment;

53. Massotherapy. Charges billed by a massotherapist unless applied in conjunction with other active physical therapy modalities for a specific illness or injury;

54. Medicare Parts A or B. Services for which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when the Covered Person is eligible for Medicare, even if the Covered Person did not apply for or claim Medicare benefits. However, if under law, the Covered Person may elect this coverage (instead of Medicare) to pay first and if does so elect, then this exclusion will not apply;

55. Milieu Therapy. Confinement in an institution primarily to change or control one's environment;

56. Military service. Treatment or services resulting from or prolonged as a result of performing a duty as a member of the military service of any state or country;

57. Nicotine transdermal patches;

58. No charge. Services for which there is no charge received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;

59. No fault. To the extent expenses are in any way reimbursable through "No-Fault" automobile insurance;

60. Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of the admission;

61. Not Medically Necessary. Any services or supplies which are not Medically Necessary, except as expressly included herein;

62. No obligation to pay. Charges Incurred for which the Covered Person has no legal obligation to pay;
63. **No Physician recommendation.** Any expenses incurred for any service or treatment which is not provided or recommended by a Physician;

64. **Norplant®;**

65. **Not specified as covered.** Services, treatment and supplies which are not specified as covered under the Plan;

66. **Notice of Claim.** Treatment, services and supplies for which proof of claim is not provided to the Plan in accordance with the When to File a Claim section;

67. **Nuclear accident;**

68. **Nutritional supplements;**

69. **Obesity.** Care and treatment of obesity, weight loss or dietary control, whether or not it is a part of the treatment plan for another Illness. This exclusion does not apply to benefits for non-surgical treatment of morbid obesity if a treatment plan has been submitted to and approved by the Plan prior to initiation of treatment. This exclusion includes Gastric Bypass surgery or any surgical interventions;

70. **Outside the United States;** Services provided for a Covered Person whose primary residence is outside of the United States. Additionally, charges incurred outside the United States if the Covered Person traveled to such a location primarily for the purpose of obtaining medical services, drugs, or supplies;

71. **Pain management services,** unless a treatment plan has been submitted to and approved by the Plan prior to initiation of treatment;

72. **Patient hygiene and convenience.** Expenses incurred in the modification of homes, vehicles, or personal property to accommodate patient convenience items. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, and personal safety alert systems, admission kits, lotion, powder, etc.;

73. **Payment prohibited by law** to the extent that payment under this Plan by any law to which you or your Dependent is subject at the time expenses are incurred;

74. **Penalties** for non-compliance with the Pre-Certification of Inpatient Services Program or non-compliance with the Safety Measures Provision;

75. **Personal comfort items.** Personal comfort items or other equipment such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, hot tubs, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and non-Hospital adjustable beds;

76. **Physical therapy admissions,** room and board of general nursing care for hospital admissions solely for physical therapy;

77. **Pre-existing conditions,** except as noted elsewhere;

78. **Premarital tests** not incidental to the treatment of a manifested injury or illness;
79. **Preoperative and postoperative visits** made by your surgeon or assistant surgeon on or after the date of your surgery, if billed as a separate line item;

80. **Realignment of the teeth of jaws** including but not limited to surgery for retrognathia or prognathism;

81. **Reimbursable through any public program.** To the extent those expenses are in any way reimbursable through any public program, except as otherwise required by law;

82. **Reimbursement.** An injury for which you are reimbursed or entitled to be reimbursed by any other party;

83. **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific injury, sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits;

84. **Sclerotherapy** for varicose veins, unless approved by the Plan prior to initiation of treatment;

85. **Self-inflicted injuries, or threatened suicide,** whether sane or insane, unless due to a medical condition;

86. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan;

87. **Services rendered or billed** for by a school or halfway house or by a member of its staff;

88. **Sex changes.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery and medical treatment, both pre and post operative care;

89. **Sleep disorders.** Care and treatment for sleep disorders, unless deemed Medically Necessary;

90. **Smoking cessation programs, services or treatment,** except as listed as covered under the Prescription Drug section;

91. **Surrogate parent agreement,** whether written or oral;

92. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization;

93. **Tax and shipping** levied on Medically Necessary items and services;

94. **Teeth or gum treatment** or the fitting or wearing of dentures. This exclusion shall not apply to treatment of accidental injury to sound natural teeth (including their replacement) for treatment received within **one year** after the date of injury;

95. **Telephone or internet consultations;**

96. **Telephone and television** service while confined as an inpatient;
97. **Temporomandibular Joint Syndrome**, all services;

98. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as defined by the Plan;

99. **Unnecessary care or treatment** as determined by a review board;

100. **Violation of law.** An Injury or Illness resulting from the voluntary use of prescription drugs, nonprescription drugs, or alcohol which the use of same constitutes or contributes to the violation of any state or federal law. It will be determined by the Plan that violation of a state or federal law has occurred if:

   a) the individual is convicted or found guilty of the applicable charges; or

   b) there is sufficient evidence that a state or federal law has been violated and no charges were brought against the individual. Sufficient evidence is defined as, but not limited to: (1) blood alcohol levels which exceed established state or federal minimums, (2) the possession of illegal nonprescription drugs, or (3) prescription/legend drugs used or taken without a written prescription;

101. **War.** Disease or Injury resulting from participation in a war, or act of war, whether declared or undeclared;

102. **Weight Loss Programs.** Weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, etc.) or fasting programs.

103. **Without Cost.** Care received without cost under the laws of the United States or any other country or government entity;

104. **Work related.** Expenses Incurred as a result of accidental bodily Injury or sickness arising out of or in the course of any occupation or employment for wage or profit, or for which the Covered Person may be entitled to benefits under any Workers Compensation or occupational disease policy, whether or not any such policy is actually in force. However, this exclusion only applies to persons who can elect, or could have elected for them, coverage under a worker’s compensation act, policy or similar law.
PRESCRIPTION DRUG BENEFITS

Retail Drug Copay:

Generic .................................................................................................................. $15.00
Formulary ............................................................................................................ $30.00
Non-Formulary ................................................................................................... $45.00

Mail Order Drugs:

Generic .................................................................................................................. $30.00
Formulary ............................................................................................................ $60.00
Non-Formulary ................................................................................................... $90.00

Mandatory Generic Provision – The patient is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand name drug. The patient payment is the price difference between the brand drug and generic drug in addition to the generic drug copayment.

The Prescription Drug Benefits provided by this Plan help to meet the cost of legend drugs. A legend drug is a compound or substance that requires, under federal law, a written prescription by a licensed Physician of medicine or osteopathy, dentist or podiatrist who is legally licensed to prescribe medications. It is a drug or medication that cannot be sold over the counter without a written prescription.

COVERED PRESCRIPTION DRUGS

Benefits include up to a 34-day supply of most legend drugs and compound prescriptions containing at least one legend drug.

The amount of drugs, including insulin, which is to be dispensed per prescription or refill, will be in quantities prescribed up to a 34-day supply.

When a Physician writes a prescription for both disposable syringes and needles and a one-month supply of insulin, the Covered Person must present the prescription to a pharmacist. If the Physician prescribes a three-month supply of insulin, coverage is provided for up to 100 disposable syringes and needles.

Prescriptions or refills can be prescribed over the telephone. Prescriptions can be refilled for the number specified by the Physician and are good for one year from the date of the prescription order.

Covered benefits include:

- Federal legend drugs
- State-restricted drugs
- Insulin
- Syringes and needles used only to inject insulin
- Chantix
- Injectable drugs, prior approval from the Claims Administrator is required.
HOW THE PLAN WORKS

Retail Plan

When the Physician writes a prescription for a covered drug item for you or for a Dependent, present the prescription and your identification card to a participating pharmacy.

Benefits are paid according to the Schedule of Benefits. Any Copayments which you make will not apply toward this Plan's Out-of-Pocket Maximum.

If you have any questions regarding your prescription coverage, you may call Mutual Health Services at 1-800-367-3762 or Partners Rx at 1-800-711-4550.

Mail Order Drug Plan

You will be able to save time and money by ordering your maintenance drugs through the Mail-Order Drug Program. Maintenance drugs can be purchased through your Mail-Order Drug Program.

To order your prescriptions, send the initial order form and attach the original prescription from your Physician. The prescription will come directly to your home.

In order to take advantage of this program, you must order at least a 30-day supply but can receive up to a 90-day supply of your maintenance drugs.

EXCLUSIONS AND LIMITATIONS

This prescription drug program does not provide benefits for the following:

1. Drugs obtained without a Physician's prescription;
2. Drugs for which the provider's Reasonable and Customary charge is less than the Copay amount of the Plan;
3. Over the counter drugs (except insulin and diabetic supplies);
4. Covered drugs for which benefits are paid elsewhere under the Plan; including but not limited to: (1) insulin; and (2) drugs used in connection with covered transplants under the transplant section;
5. Drugs not requiring a prescription under federal law;
6. Any charge for contraceptive medication unless a letter of Medical Necessity is provided stating that the medication is not for birth control;
7. Fertility drugs/agents;
8. Cosmetic drugs;
9. Charges for growth hormones, unless prior approval is obtained by the Plan;
10. Charges for Retin-A or similar products for those over age 21;
11. Drugs which sole purpose are to promote or stimulate hair growth;
12. Any charge for therapeutic devices or appliances, regardless of their intended use (except for disposable insulin syringes); support garments; medical supplies and equipment; other non-medical items regardless of their intended use;

13. Any charge for administration of drugs or insulin;

14. The charge for more than a 34-day supply of retail legend drugs or a 90 day supply of mail order legend drugs;

15. The charge for any prescription order refill in excess of the number specified by a doctor or any refill dispensed after one year from the date of the original prescription order;

16. Immunizing agents, biological sera, blood or plasma, laterite;

17. Dietary supplements and vitamins except prenatal vitamins used while receiving maternity benefits;

18. Health and beauty aids;

19. Drugs labeled "Caution: limited by Federal law to investigational use" or experimental drugs, even though a charge is made;

20. Drugs taken or given while at a Hospital, convalescent care facility, or similar institution;

21. Fluoride preparations;

22. Weight control/Anti-Obesity Drugs;

23. Non-legend drugs, other than insulin;

24. Norplant®;

25. Impotency agents/Drugs (Viagra, MUSE, etc.) and injectable drugs; except as determined to treat a medical illness. Prior approval must be obtained by the Plan;

26. The charge for any medication for which you or your eligible Dependent is entitled to receive reimbursement under any Worker's Compensation law, or for which entitlement to benefits is available without charge from any municipal, state or federal program of any sort, whether contributory or not;

27. Drugs which do not have the required governmental approval when you receive them or are considered Experimental, investigative, or of a research nature; and

28. Drugs and medicines not covered under the Plan. Please see the General Limitations and Exclusions section.

PLEASE NOTE: If your Medical coverage terminates or if your eligible Dependent's Medical coverage terminates, coverage under this program also terminates. If you continue to use your prescription drug card, you will be held responsible for payment of any charges Incurred on or after such termination date.
CLAIMS PROCEDURES

Types of Claims

How you file a claim for benefits depends on the type of claim it is. There are several categories of claims for benefits:

Pre-Service Care Claim - A pre-service claim is a claim for a benefit under the Plan which the terms of the Plan require approval of the benefit in advance of obtaining medical care. There are two special kinds of pre-service claims:

Urgent Care Claim - An urgent care claim is any pre-service claim for medical care or treatment where applying the timeframes for non-urgent care could (a) seriously jeopardize your life or health or your ability to regain maximum function or (b) in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies. Determination of urgent can be made by (a) an individual acting on behalf of the plan and applying the judgment of a prudent lay person who possesses an average knowledge of medicine or (b) any Physician with knowledge of your medical condition can determine that a claim involves urgent care.

Concurrent Care Claim - A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved pre-service claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. Additionally, if the Plan or its designee reduces or terminates a course of treatment before the end of the course previously approved (unless it's due to a health plan amendment or health plan termination), then the reduction or termination is considered an adverse benefit determination. The Plan or its designee will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

Post-Service Care Claim - A Post-Service Claim is a claim for payment or reimbursement after services have been rendered. It is any claim that is not a pre-service claim.

Who Must File

You may initiate pre-service claims yourself if you are able or your treating Physician may file the claim for you. You are responsible for filing post-service claims yourself, although the Plan or its designee may accept billings directly from providers on your behalf, if they contain all of the information necessary to process the claim.

Appointing an Authorized Representative. If you or your Dependent wish to have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals, you must furnish the Plan or its designee with a written designation of your Authorized Representative. You can appoint any individual as your Authorized Representative. A Health Care Provider with knowledge of your medical condition can act as your Authorized Representative for purposes of
an urgent care claim as defined above without a written designation as Authorized Representative. Once you appoint an Authorized Representative in writing, all subsequent communications regarding your claim will be provided to your Authorized Representative.

Time Limit for Filing a Claim

You must file claims within 12 months of receiving Covered Services. Your claim must have the data the Plan needs to determine benefits. Should you receive a request for additional information, this must be provided within the initial 12 months.

Where to File a Claim

Claims should be filed as indicated on your Identification Card.

What to File

The Plan Administrator and the Claims Administrator furnish claim forms. When filing claims, you should attach an itemized bill from the Health Care Provider. The Claims Administrator may require you to complete a claim form for a claim. Please make sure that the claim contains the following information:

- Employee's Name and Social Security Number or Alternate ID Number
- Patient's Name
- Name of Company/Employer

Method of Claims Delivery

Pre-service claims may be initiated by telephone. The Plan may require you to provide follow-up paperwork in support of your claim.

Other claims may be submitted by U.S. Mail, by hand delivery, by facsimile (FAX), or as a HIPAA compliant electronically filed claim.

Timing of Claims Determinations

Urgent Care Claims. If your claim involves urgent care, you or your authorized representative will be notified of the Plan's or its designee's initial decision on the claim, whether adverse or not, as soon as is feasible, but not later than 72 hours after receiving the claim. If the claim does not include sufficient information for the Plan or its designee to make an intelligent decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; the Plan or its designee then must inform you of its decision within 48 hours of receiving the additional information. The Plan or its designee may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

Concurrent Care Claims. If your claim is one involving concurrent care, the Plan or its designee will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim, if the claim was for urgent care and was received by the Plan or its designee at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. You will be given time to provide any additional information required to reach a decision. If your concurrent care claim does not involve urgent care or is filed less than 24
hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan or its designee will respond according to the type of claim involved (i.e., urgent, other pre-service or post-service).

**Other Pre-Service Claims.** If your claim is for any other pre-service authorization, the Plan or its designee will notify you of its initial determination, whether adverse or not, as soon as possible, but not more than 15 days from the date it receives the claim. This 15-day period may be extended by the Plan or its designee for an additional 15 days if the extension is required due to matters beyond the Plan's control. The Plan or its designee will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, the Plan or its designee will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will have at least 45 days to provide any additional information requested of you by the Plan or its designee.

**Post-Service Claims.** If your claim is for a post-service reimbursement or payment of benefits, the Plan or its designee will notify you within 30 days of receipt of the claim that the claim has been approved or denied. The 30 days can be extended to 45, if the Plan notifies you within the initial 30 days of the circumstances beyond the Plan's or its designee's control that require an extension of the time period, and the date by which the Plan expects to render a decision.

If more information is necessary to decide a post-service claim, the Plan or its designee will deny the claim and notify you of the specific information necessary to complete the claim.

**Notice of Claims Denial (Adverse Benefit Determination)**

If, for any reason, your claim is denied, in whole or in part, you will be provided with a written notice containing the following information:

1. The reason(s) why the claim or a portion of it was denied;
2. Reference to plan provisions on which the denial was based;
3. If the denial relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;
4. If the denial was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;
5. What additional information, if any, is required to perfect the claim and why the information is necessary; and
6. A description of the Plan's or its designee's appeal procedures and applicable time limits, including the expedited appeal process, if applicable.

**FILING A COMPLAINT**

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the Employee should have the following information available:

- name of patient
• identification number
• claim number(s) (if applicable)
• date(s) of service

If your complaint is regarding a claim, a Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Summary Plan Description, the Customer Service representative will telephone the Employee with the response. If attempts to telephone the Employee are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Employee will receive a check, Explanation of Benefits or letter explaining the revised decision.

If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

How and When to File a Claims Appeal

If you dispute a denial of benefits, you may file an appeal within 180 days of receipt of the denial notice. This appeal must be in writing (unless the claim involves urgent care, in which case the appeal may be made orally). Your request for review must contain the following information:

1. Your name and address;
2. Your reasons for making the appeal; and
3. The facts supporting your appeal.

You can submit your appeal by calling 1-800-367-3762. You may also submit your appeal in writing by sending your request to:

Member Appeals
PO Box 4138
Akron, Ohio 44321
1-800-367-3762

First Level Mandatory Internal Appeal

In connection with your right to appeal the initial claims determination, you also:

1. May review pertinent documents and submit issues and comments in writing;
2. Will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;
3. Will, at your request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
4. Will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The claim review will be subject to the following rules:

1. The claim will be reviewed by an appropriate party, who is neither the individual who made the initial denial nor a subordinate of that individual.
2. The review will be conducted without giving deference to the initial denial.
3. If the initial denial was based in whole or in part on a medical judgment (including any determinations of Medical Necessity or Experimental/Investigative treatment), the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This medical expert shall not be an individual who was consulted on the initial claim denial nor the subordinate of such an individual. Any medical experts consulted in the review process shall be identified by name. Health care professionals who conduct the appeal act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits.

Timetable for Deciding Appeals

The Plan Administrator must issue a review decision on your appeal according to the following timetable:

Urgent Care Claims - not later than 72 hours after receiving your request for a review.

Pre-Service Claims - not later than 30 days after receiving your request for a review.

Post-Service Claims - not later than 30 days after receiving your request for a review.

Decisions will be issued on concurrent claim appeals within the time frame appropriate for the type of concurrent care claim (i.e., urgent, other pre-service or post-service).

Notice of Decision on Appeal

If the appeal has been either partially or completely denied, you will be provided with a written notice containing the following information:

1. The specific reasons for the appeal denial;
2. Reference to the specific plan provisions on which the denial is based;
3. A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;
4. If the appeal denial relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided to you without charge;
5. If the appeal denial was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge; and
6. A description of the Plan's or its designee's appeal procedures and applicable time limits, including the expedited appeal process, if applicable.
Second Level Review Process for Public Employee Benefit Plans

If your plan is a public employee benefit plan, the following second level review process may be available.

Your Right to an Independent Review for Non-Covered Services by the Ohio Department of Insurance

You have the right to request a review by the Ohio Department of Insurance in certain circumstances as described below. You may contact the Ohio Department of Insurance at the following address:

Ohio Department of Insurance
Consumer Services Division
50 W. Town Street, Third Floor - Suite 300
Columbus, Ohio 43215-4186

If the Plan or its designee denied, reduced or terminated coverage for a health care benefit because the Plan or its designee determined that the benefit was not covered under your Summary Plan Description, you have the right to request a review by the Ohio Department of Insurance. If the Ohio Department of Insurance reviews your case and cannot make a determination because it requires resolution of a medical issue, the Department will notify the Plan or its designee and the Plan or its designee will initiate an external review as described below. If the Department of Insurance reviews your case and determines that the health service is a covered benefit, the Plan or its designee must either cover the service or allow you the opportunity of an external review.

Second Level External Review Process by the Ohio Department of Insurance for Medical Necessity Denial

In accordance with state law, the Plan or its designee has established an external review process to examine coverage decisions under certain circumstances. You may be eligible to have a decision reviewed by the external review process if you meet the following criteria:

1. The Plan or its designee has denied, reduced, or terminated coverage for what would be a covered health care service except for the fact that the Plan or its designee determined that the service is not Medically Necessary;
2. The proposed service, plus any ancillary services and follow-up care, will cost you $500.00 or more if it is not covered; and
3. You have exhausted the mandatory internal appeal process.

You are NOT entitled to External Review if:

1. The Ohio Department of Insurance determined that the health care service is not a Covered Service under the Plan; or
2. You have already had an external review for the same adverse determination and no new pertinent clinical information has been submitted.

External Review will be conducted by independent review organizations accredited by the Ohio Department of Insurance. You will not be required to pay for any part of the cost of the external review. The Plan is required by law to provide to the independent review organization conducting the review a copy of the records that are relevant to your medical Condition and the external review.
The request for External Review must be made within 180 days from your receipt of the notice of denial from the first-level, internal appeal.

**External Review for Non-Urgent Care Claims Appeals**

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to Member Appeals at the address listed above. It can be made by you or your Provider. Your Provider may not, however, request an external review without your prior written consent. A request must be accompanied by written certification from your Provider that the proposed service, plus any ancillary services and follow-up care, will cost you $500 or more if the proposed service is not covered by the Plan.

The review panel will issue a written decision within 30 days after you have submitted the request. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. The Plan or its designee will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Summary Plan Description.

**External Review for Urgent Care Claim Appeals**

A request for an external review for Urgent or Expedited claims may be requested orally or electronically with a written confirmation not later than five days after the request is submitted. A request for an expedited review should be made by calling Member Appeals at 1-800-367-3762, or writing to Member Appeals at the address listed above. It can be made by you or your Provider. Your Provider, may not, however, request an external review without your prior written consent.

A request for an expedited review must be certified by your Provider that your Condition could, without immediate medical attention, result in any of the following:

1. Seriously jeopardize your life or health or your ability to regain maximum function or, with respect to a pregnant woman, place the health of her unborn child in serious jeopardy; or

2. In the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The review panel will issue a written decision within seven calendar days after you have submitted the request. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. The Plan or its designee will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Summary Plan Description.

**External Review for Terminal Conditions**

If you have a terminal Condition, you are eligible to have an external review if you meet all of the following criteria:

1. You have a terminal Condition that, according to the current diagnosis of your Physician, has a high probability of causing death within two years; and

2. Your Physician certifies that one of the following situations applies to your terminal Condition:
   a. standard therapies have not been effective in improving your Condition;
   b. standard therapies are not medically appropriate for you;
c. no standard therapy, covered by the Plan, is more beneficial than a therapy recommended by your Physician or requested by you; and

3. Your Physician has recommended a drug, device, procedure, or other therapy that your Physician certifies, in writing, is likely to be more beneficial to you, in the Physician's opinion, than standard therapies, or you have requested a therapy found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same Condition; and

4. You have been denied coverage by the Plan or its designee for the drug, device, procedure or other recommended or requested therapy and have exhausted all internal appeals; and

5. The drug, device, procedure or other recommended or requested therapy would be a Covered Service except for the Plan's or its designee's determination that the drug, device, procedure or other therapy is Experimental or Investigational.

You must request the review in writing unless your Physician determines that the therapy would be significantly less effective if not started immediately. You will not be required to pay for any part of the cost of the external review. The review panel will issue a written decision within seven calendar days after you have submitted the request. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. The Plan or its designee will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Summary Plan Description.

**Second Level Voluntary Internal Appeal**

Unless the Plan requires you to use an alternative dispute resolution procedure, if your first level mandatory appeal is denied, and you do not qualify for an External Review by the Ohio Department of Insurance, because the cost to you is less than $500, then you may have the option of a voluntary second level appeal by the Plan or its designee. To learn more about whether the Plan offers a voluntary second level internal appeal, the particular process, and how to submit a request for appeal, you may call 1-800-367-3762.

**LEGAL ACTION**

You may not begin any legal action until you have followed the procedures and exhausted the administrative remedies described in this section. These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. No action, at law or in equity, shall be brought to recover benefits within 60 days after Mutual Health Services receives written proof in accordance with this Summary Plan Description that Covered Services have been given to you. No such action may be brought later than three years after expiration of the required claim filing limit as specified.

**HEALTH CARE FRAUD**

Health care fraud is a felony that can be prosecuted. Any Participant who willfully and knowingly engages in an activity intending to defraud this Plan will face disciplinary action and / or prosecution. Furthermore, any Participant who receives money from the Plan to which he is not entitled will be required to fully reimburse the Plan.

**PLAN AMENDMENTS**

Plan amendments are required to be distributed to all eligible Employees within 60 days of the effective date of the amendment.
RIGHT TO RELEASE CLAIMS AND RECEIVE NECESSARY INFORMATION

For the purpose of implementing the terms of this coverage, Mutual Health Services may, without the consent of or notice to any person, release or obtain from any insurance company or other organization or person any information, with respect to any person, which it deems necessary for determining benefits payable.

PHYSICAL EXAMINATION

Mutual Health Services shall, upon request and at the expense of The Plan and by a Physician of its own choice, have the right and opportunity to physically examine any covered individual with respect to the surgical and medical services listed in the Summary Plan Description.

FACILITY OF PAYMENT

When another plan makes payment that should have been made under this Plan, the Plan shall have the right to directly reimburse the other plan making payment.

RIGHT OF RECOVERY

If the Plan makes any payment which is determined in excess of the Plan’s benefits, the Plan shall have the right to recover the amount determined to be in error. The Plan shall have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

RESCISSION OF COVERAGE

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan.

Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer. You will be provided with thirty (30) calendar days’ advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Individuals will be protected from discrimination in health plans on the basis of their genetic information. The Plan will not discriminate against individuals based upon their genetic information, which includes information about genetic tests, the genetic test of family members and the manifestation of a disease or disorder in family members. In addition, genetic information will be considered “health information” for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
LARGE CASE MANAGEMENT

Large case management is a program which identifies potential high risk, high cost claims in order to direct the patient toward the most cost-effective, quality medical care available, as well as provide the patient and the patient's family with another avenue for information and options.

When a Covered Person's condition warrants (i.e. chronic illness, catastrophic injury, etc.) the Plan shall have the right to initiate case management and waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrifice to the quality of patient care. The Case Manager will first contact the patient and/or the patient's family to introduce themselves and answer questions. The Case manager will also contact the patient's attending Physician and other medical providers to introduce themselves and to assure that all available resources are considered.

Should an alternate treatment plan be proposed, the Case Manager, attending Physician, patient, and patient's family must all agree to the alternate treatment plan. However, the patient and/or patient's family cannot refuse to cooperate with the case management firm including signing necessary authorization forms to obtain health information.

COORDINATION OF BENEFITS

Coordination of benefits (COB) is a feature of this Plan that prevents duplicate payment of covered charges if a Plan participant is covered under more than one benefits program. In order to ensure that you receive the maximum benefits if you have duplicate coverage, always present both ID cards and take the claim forms (if required) from both benefits programs when you receive a service.

Determining the Primary Payer

Several rules are used to determine which benefit plan is the primary payer (or primary carrier) if a person is covered by more than one plan. The rules for primary payer are applied in the following order:

- A benefits plan that does not have a COB feature is always the primary payer.

- In the event of a motor vehicle accident, this Plan is not primary. This includes, but may not be limited to, auto medical insurance coverage, no-fault coverage, casualty, or liability insurance.

- A benefits plan that covers the patient as the employee is the primary payer and pays before a plan that covers that patient as a dependent.

- A benefits plan that covers the patient as an active employee is the primary payer and pays before a plan that covers the patient as an inactive employee.

- If a child is covered under both parents' plans, the plan covering the parent whose birthday occurs earlier in the year pays before the plan covering the other parent.

- If the child's parents are divorced or separated, the primary payer is determined in the following order:

  - The plan of the parent who by court order is responsible for the child's health care expenses is the primary plan.
If there is no decree, the plan that covers the child as a dependent of the parent who has custody of the child is the primary payer. The plan of the non-custodial parent is secondary.

If there is no decree, the plan that covers the child as a dependent of the parent who has custody of the child is the primary payer, and if the custodial parent remarries, the plan of the custodial parent's spouse is secondary. The plan of the non-custodial parent is tertiary.

- A benefits plan that covers the patient as a COBRA beneficiary will be secondary payer to any other health plans.

- If not one of the above rule applies, the plan covering the plan participant for a longer period of time pays before the plan covering the plan participant for the shorter period of time.

When you receive duplicate payment from the Plan and another health benefits plan, the Plan will collect that duplicate payment from you.

When this Plan Is Secondary

Determining how much this Plan will pay as your secondary plan can be confusing. There are some basics to remember that will help you understand how COB works.

- As secondary payer, this Plan pays benefits after your primary plan has paid.
- This Plan will never pay more as the secondary plan than it would have paid if it had been the primary plan.

With COB, this Plan's benefits are paid up to this Plan's Benefit Level. This means that if you are covered by more than one plan and this Plan is determined to be the secondary payer, this Plan pays this Plan's benefit minus what the primary plan paid. So, if this Plan's benefit is determined to be $400, and the primary plan pays $720, this Plan will pay nothing, because $400 minus $720 is a negative amount. If this Plan's benefit is determined to be $400, and the primary plan pays $320, this Plan will pay $80, because $400 minus $320 is $80.

Coordination of Benefits and Group Plans

The COB provision applies to other group medical benefits plans. These plans include:

- group, blanket, or franchise insurance coverage;
- Blue Cross, Blue Shield, or other prepayment coverage;
- coverage under a labor-management trusteed plan;
- any union welfare plan;
- an employer organization plan or employee benefit organization plan;
- coverage under any law, including any federal or state or other governmental plan or law, toward the cost of which any employer shall have made payroll deductions;
- coverage under any plan solely or largely tax supported or otherwise provided for, by, or through action of any government.
Any benefits you may receive from personal, individual policies (other than auto) do not affect the coordination of your benefits under this Plan.

**Coordination of Benefits and Medicare**

**Active Employees Age 65 or Over**

Medicare coverage is secondary to the Plan for an active Employee, age 65 or over, and a spouse, age 65 or over, of such active Employee. Medicare is also secondary for any disabled covered Dependents. Medicare coverage, even on a secondary basis, can provide valuable benefits. You should apply when eligible for Medicare Part A, since there is no premium charge and this Plan will not pay for any expenses Medicare otherwise would have paid had you enrolled.

Because of this Medicare secondary provision, it is important that you have certain information concerning the Plan and Medicare:

- If you and/or your spouse are not presently enrolled in the Plan, you and/or your spouse may request coverage at any time. However, requested coverage is subject to the Plan's normal eligibility and effective date provisions.

- If you and your spouse are presently covered under the Plan, you may remain covered while you continue active employment unless you request, in writing, that coverage be terminated.

- A person becomes eligible for Medicare upon attainment of age 65 if he or she is then qualified for Social Security retirement benefits.

- Medicare coverage is divided into two parts. Medicare Part A (Hospital) coverage is provided at no cost. Medicare Part B (Surgical and Medical) coverage requires payment of a monthly premium.

- To enroll for Medicare, contact the nearest Social Security office prior to attainment of age 65. Also, a booklet entitled "Your Medicare Handbook" is available from any Social Security office. This booklet is free and provides a detailed description of Medicare benefits.

**Note:** For active Employees, age 65 or over, and for spouses, age 65 or over, federal law requires that Medicare be a secondary payer and pay after an employer-sponsored medical plan, under which these active Employees and spouses are covered. However, an active Employee, age 65 or over, has the option of rejecting the employer-sponsored medical plan with the result that Medicare becomes the primary payer. Rejection of this employer-sponsored medical plan should be submitted, in writing, to the Benefits Department. If you have elected Medicare as your primary form of health insurance, you are excluded from coverage under The National Mutual Insurance Company Group Health Plan.

All persons should carefully review their options when they become eligible for Medicare Part B. Persons who do not elect Medicare Part B when first eligible, and who later wish to obtain Medicare Part B coverage, must usually serve a waiting period and are charged an increased monthly premium. The waiting period and the increased premium, however, are waived for all persons during the period their Medicare coverage is secondary to The National Mutual Insurance Company Group Health Plan.
If Medicare coverage for you or your spouse will be (or is now) secondary to the Plan, and if you wish to reject or delay Medicare Part B, contact the Social Security Administration as early as possible.

**Plan Participants with Permanent Kidney Failure**

Medicare is secondary payer to an employer's group health plan for up to 30 months for beneficiaries who have Medicare solely because of permanent kidney failure. At the end of the 30-month period, Medicare becomes the primary payer until your Medicare coverage for permanent kidney failure ends. For further information, check with your nearest Social Security office or the Medicare insurance carrier in your area.

**RIGHT OF SUBROGATION AND REFUND / THIRD PARTY RECOVERY**

**When This Provision Applies**

The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of another party or another party may be responsible for payment. In such circumstances, the Covered Person may have a claim against another party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns this Plan any rights the Covered Person may have to recover payments from any other party or insurer. This Subrogation right allows this Plan to pursue any claim which the Covered Person may have to recover payments from any other party or insurer. This Subrogation right allows this Plan to pursue any claim which the Covered Person has against any other party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the other party or insurer, but in any event, this Plan has a first priority lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This first priority lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

1. Automatically assigns to this Plan his or her rights against any other party or insurer when this provision applies; and
2. Must repay to this Plan benefits paid on his or her behalf out of the Recovery made from the other party or insurer.

**Amount Subject to Subrogation or Refund**

The Covered Person agrees to recognize this Plan's first priority right to Subrogation and reimbursement. These rights provide this Plan with a first priority with respect to any funds paid by another party to a Covered Person relative to the Injury or Illness, even if the Covered Person is only partially compensated for all losses. The Plan's priority recovery right includes a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Any so-called "make whole" or "full compensation" rule or doctrine is hereby explicitly rejected and disavowed.

Notwithstanding its priority to Refunds, this Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which this Plan has made, or will make, payments for medical or dental charges, as well as any costs and fees associated with the enforcement of its rights under this Plan.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure this Plan's right of

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subrogation as a condition to having this Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of this Plan to subrogate.

Defined Terms

“Recovered / Recovery” means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or Illness whether or not said losses reflect medical or dental charges covered by this Plan.

“Subrogation” means this Plan’s rights to pursue the Covered Person’s claims for medical or dental charges against the other person.

“Refund” means repayment to this Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Illness.

Note: As used only in this provision, the term “Covered Person” is deemed to include any legal or personal representative, parent, guardian, or estate of the Covered Person.

Recovery from another Plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner’s plan, renter’s plan, medical malpractice plan, or any liability plan.

PROVISIONS APPLICABLE TO ALL COVERAGE

The Plan Sponsor reserves the right to terminate, suspend, withdraw, amend, or modify the Plan at any time. Any such change or termination in benefits (a) will be based solely on the decision of the Plan Sponsor; and (b) may apply to active Employees or present and future retirees as either separate groups or as one group.

Any representations or statements which disagree with the provisions of the Plan as stated herein, which are made by the Plan Sponsor, Plan Administrators, Representatives or Agents, plan Participants or providers:

1. Shall not be considered as representations or statements made by, or on behalf of the Plan; Plan Sponsor or Administrator;
2. Shall not bind Plan Administrator for benefits under the Plan.

TERMINATION OF EMPLOYEE COVERAGE

Your coverage under this plan will terminate automatically without notice as of midnight of the last day of the month in which the earliest of the following occurs:

1. The date the Plan terminates and/or is dissolved.
2. The last day of the month you cease active work with The National Mutual Insurance Company (or your severance period is completed).
3. The date that you die.
4. When you cease your contributions toward the Plan.
5. The date you enter into military service, other than for a duty of less than 30 days, or as specified in the USERRA section of this plan.
6. The day your status as an eligible Employee changes.
7. The date the Plan is amended to make your employment classification ineligible.
8. The date you or your covered Dependents defraud or attempt to defraud the Plan.
TERMINATION OF DEPENDENT COVERAGE

For a Dependent, as of midnight on the earliest of the following dates:

1. When the Employee's coverage terminates.
2. When the Employee ceases to make the required contribution regarding Dependent coverage.
3. The date the child becomes covered as an Employee.
4. The last day of the Calendar month the child reached the applicable age for Dependent children.
5. When this Plan is terminated and/or discontinued.

For a Dependent Spouse, as of midnight on the earliest of the following dates:

1. When the Employee's coverage terminates.
2. When the Employee ceases to make the required contribution regarding Dependent coverage.
3. The date the Spouse becomes covered as an Employee.
4. The last day of the calendar month the Spouse is legally separated or divorced from the Employee.
5. When this Plan is terminated and/or discontinued.

CONTINUATION OF COVERAGE FOR PERSONAL LEAVE OF ABSENCE

If you are a full-time Employee and obtain an approved personal leave of absence, you (and your covered Dependents) may be eligible for continuation of medical coverage under this Plan as described in the Continuation of Your Group Health Plan (COBRA) section.

FAMILY AND MEDICAL LEAVE

If you take a leave of absence in accordance with the federal Family and Medical Leave Act of 1993, coverage for you and your Dependents will be continued under the same terms and conditions as if you have continued performing services for The National Mutual Insurance Company, provided you continue to pay your regular contribution towards coverage.

If you fail to make the required contribution for coverage within the 30-day grace period from the contribution due date, then your coverage will terminate as of the date the contribution was due.

If you do not return to work for The National Mutual Insurance Company after the approved Family Medical Leave, or if you have given notice of intent not to return to work during the leave, or if you exhaust your FMLA entitlement, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided you elect to continue under the COBRA provision. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

1. You were covered under this Plan on the day before the FMLA leave began or became covered during the FMLA leave;
2. You do not return to work after an approved FMLA leave; and
3. Without COBRA, you would lose coverage under this Plan.

Continuation of Coverage (COBRA) will become effective on the last day of the FMLA leave as determined below:

1. The date you fail to return to work after an approved Family or Medical Leave;
2. The date you inform The National Mutual Insurance Company that you do not intend to return to work; or
3. The date you exhaust your FMLA entitlement and fail to return to work.

Coverage continued during a Family or Medical Leave will not be counted toward the maximum COBRA continuation period.

If you decline coverage during the FMLA leave period, or if you elect to continue coverage during the Family or Medical Leave and fail to pay the required contributions, you will still be eligible for COBRA continuation at the end of the FMLA leave, if you do not return to work. COBRA continuation will become effective on the last day of the FMLA leave. You need not provide evidence of good health to elect COBRA continuation, even if there was a lapse in coverage during the FMLA leave period.

If coverage lapses for any reason during an FMLA leave and you return to work on a timely basis following an approved FMLA leave, coverage will be reinstated as if you have continued performing services during the leave, including Dependent coverage. Reinstatement will be provided without having to satisfy any waiting period, or provide evidence of good health.

CONTINUATION OF COVERAGE FOR DISABILITY

If you are a full-time Employee and become disabled and obtain an approved, paid, medical leave of absence, you (and your covered Dependents) are eligible for continuation of medical benefits under the Plan for up to 6 months from the date of disability (or from the date of leave), provided you continue to pay your portion (single or family) of the coverage costs and you are an Employee of The National Mutual Insurance Company. This means that The National Mutual Insurance Company continues to pay its portion of the cost of coverage for you, the Employee. If, at the end of 6 months of coverage for disability, you continue to be disabled, you may be eligible for continuation of coverage as described in the Continuation of Your Group Health Coverage (COBRA) section.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

In compliance with the requirements of the HIPAA regulations, herein referred to as the “HIPAA Privacy Rule”, the following has been established as the extent to which the Plan Sponsor will receive, use, and/or disclose Protected Health Information.

Permitted disclosure of individuals’ Protected Health Information to the Plan Sponsor

A. The Plan (and any business associate acting on behalf of the Plan), or any health care issuer servicing the Plan will disclose individuals’ Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this regulation.

B. All disclosures of the Protected Health Information of the Plan’s individuals by the Plan’s business associate or health care issuer, to the Plan Sponsor will comply with the restrictions and requirements set forth in this document and in the “504” provisions.

C. The Plan (and any business associate acting on behalf of the Plan), may not permit a health care issuer, to disclose individuals’ Protected Health Information to the Plan Sponsor for employment-related actions and decisions in connection with any other benefit or employee benefit plan of the Plan Sponsor.
D. The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

E. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's business associate or health care issuer), agrees in writing to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

F. The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

Disclosure of individuals' Protected Health Information - Disclosure by the Plan Sponsor

A. The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.

B. The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.

C. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

D. The Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

E. The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a business associate or health care issuer with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

F. The Plan Sponsor will ensure that the required adequate separation, described later in this section, is established and maintained.
Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

A. The Plan, or a business associate or health care issuer with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health coverage under the Plan; or
2. Modifying, amending, or terminating the Plan.

B. The Plan, or a business associate or health care issuer with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Required separation between the Plan and the Plan Sponsor

A. In accordance with the "504" provisions, this section describes the Employees or classes of Employees or workforce members under the control of the Plan Sponsor who may have access to individuals’ Protected Health Information received from the Plan or from a business associate or health care issuer servicing the Plan.

1. Human Resources
2. Sr. VP of Finance and Treasurer
3. Accounting
4. Accounting Services

B. This list reflects the Employees, classes of Employees, or other workforce members of the Plan Sponsor who may receive or at times access individuals’ Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals’ Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals’ Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

C. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA SECURITY STANDARDS

The Plan Documents of The National Mutual Insurance Company Group Health Plan are hereby amended as follows:
Definitions

A. *Electronic Protected Health Information* – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.


C. *Plan Documents* – The term "Plan Documents" means the group health plan's governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to The National Mutual Insurance Company Group Health Plan Document.


E. *Security Incidents* – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

A. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;

B. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f) (2) (iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

C. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

D. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarterly, or more frequently upon the Plan's request.
COBRA COVERAGE

SUMMARY OF RIGHTS AND OBLIGATIONS REGARDING CONTINUATION OF COVERAGE UNDER THE BENEFIT PLAN

Federal law requires most employers sponsoring group health plans to offer Employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under the group health plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the cost of your continuation coverage.

This section is intended only to summarize, as best possible, your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the Employee) and your Spouse should read this summary carefully and keep it with your records.

Qualifying Events

If you are an Employee of The National Mutual Insurance Company and you are covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any of the following "qualifying events":

1. Termination (for reasons other than your gross misconduct) of your employment.
2. Reduction in the hours of your employment.
3. Disability Determination

If you are the Spouse of an Employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following five "qualifying events":

1. The death of your Spouse.
2. A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment with The National Mutual Insurance Company.
3. Divorce or legal separation from your Spouse. (Also, if an Employee drops his or her Spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later event will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the administrator within 60 days of divorce and can establish that the coverage was dropped earlier in anticipation of divorce, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your Spouse becomes entitled to Medicare benefits.
5. Your Spouse becomes disabled.

In the case of a Dependent child of an Employee covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following six "qualifying events":

1. The death of the Employee parent.
2. The termination of the Employee parent's employment (for reasons other than gross misconduct) or reduction in the Employee parent's hours of employment with The National Mutual Insurance Company.

3. Parents' divorce or legal separation.

4. The Employee parent becomes entitled to Medicare benefits.

5. The Dependent ceases to be a "Dependent child" under the Plan.

6. Employee parent becomes disabled.

Notices and Election Procedures

Your employer is responsible for notifying the plan administrator of certain qualifying events, such as termination of employment (other than gross misconduct), reduction of hours, death and Employee's Medicare entitlement. You (the Employee) and/or your qualified beneficiaries will be notified of the right to elect continuation coverage automatically (i.e., without any action required by you or a family member) upon these events that resulted in a loss in coverage.

Under the COBRA statute, you (the Employee) or a family member have the responsibility to notify the Plan Administrator upon a divorce, legal separation, a child losing Dependent status, or a disability determination. This notice is required to be submitted to your Plan Administrator in writing. You must contact your Plan Administrator to obtain a "Notice from Qualified Beneficiary of Qualifying Event Form" to provide proper notice. The form provides information as to whom and where the Notice is to be sent. You or a family member must provide this notice within 60 days of the date of the qualifying event, or the date coverage is lost, whichever is later.

Notification of a second qualifying event must be made to the Plan Administrator within 60 days of the qualifying event, and must be in writing as described in the above paragraph.

Notification of a disability determination must be made to the Plan Administrator within 60 days of the LATER of the date of determination, date of qualifying event, or date coverage is lost as a result of the qualifying event. Notification must be in writing as described in the above paragraph, and a copy of the SSA Determination must accompany your notice. Please note you have 30 days from the determination to notify Plan Administrator that you are no longer disabled.

If you or family members fail to provide this notice to the Plan Administrator during this 60-day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member, fail to notify the Plan Administrator, and any claims are paid mistakenly for expenses Incurred after the last day of coverage, then you and your qualified beneficiaries will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is provided timely notice of a divorce, legal separation, a child's losing Dependent status, or a disability determination that has caused a loss of coverage, the Plan Administrator will notify the affected family member of the right to elect continuation coverage.

You (the Employee) or your qualified beneficiaries must elect continuation coverage within 60 days after Plan coverage ends or, if later, 60 days after the Plan Administrator sends you or your family member notice of the right to elect continuation coverage.

If you or your qualified Beneficiaries do not elect continuation coverage within this 60-day election period, you or your qualified Beneficiaries will lose the right to elect continuation coverage. Once the election is sent to the Plan Sponsor it is effective back to the date the
employer sponsored coverage was lost. Please Note: No claims will be paid until the COBRA payment is received.

A covered Employee or the Spouse of the covered Employee may elect continuation coverage for all qualified beneficiaries. The covered Employee and his or her Spouse and Dependent children each also have an independent right to elect continuation coverage. Thus, a Spouse or Dependent child may elect continuation coverage even if the covered Employee does not (or is not deemed to) elect it.

You or your qualified beneficiaries can elect continuation coverage if you or the family member, at the time you or the family member elect continuation coverage, are covered under another employer-sponsored group health plan or are entitled to Medicare.

**Type of Coverage; Payments of Contributions**

Ordinarily, you or your qualified beneficiaries will be offered COBRA coverage that is the same coverage that you, he or she had on the day before the qualifying event. Therefore, a person (Employee, Spouse or Dependent child) who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage for similarly situated Employees or their family members is modified, COBRA coverage will be modified the same way.

The premium payments for the "initial premium months" must be paid for you (the Employee) and any qualified beneficiaries by the 45th day after electing continuation coverage. The initial premium months begin from the date you lost your employer sponsored coverage, and end on or before the 45th day after the date of the COBRA election. All other premiums are due on the 1st day of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is made on the date it is post-marked or actually received; whichever is earlier.

**Maximum Coverage Periods**

**36 Months.** If you (Spouse or Dependent child) lose group health coverage because of the Employee's death, divorce, legal separation, or the Employee's becoming entitled to Medicare, or because you lose your status as a Dependent under the Plan, the maximum continuation coverage period (for Spouse and Dependent child) is 36 months from the date of the qualifying event.

If employee is entitled to Medicare at the time of or after the initial qualifying event, please see Item 3 under Exceptions below.

**18 Months.** If you (Employee, Spouse or Dependent child) lose group health coverage because of the Employee's termination of employment (other than for gross misconduct), reduction in hours, or disability determination the maximum continuation coverage period (for the Employee, Spouse and Dependent child) is 18 months from the date of termination or reduction in hours.

If employee is entitled to Medicare at the time of or after the initial qualifying event, please see Item 3 under Exceptions below.
Exceptions. There are three exceptions:

1. If an Employee or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to The Company or the Plan Administrator both within the 18-month coverage period and within 60 days after the date of the determination.

2. If a second qualifying event that gives rise to a 36-month maximum coverage period (for example, the Employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours for the Spouse or dependent child.

3. If within the 18 month period after Medicare entitlement, the Employee experiences a qualifying event (due to termination or reduction of hours worked) then the period of continuation for family members, other than the Employee, who are qualified beneficiaries, is up to 36 months from the date of Medicare entitlement.

If the Employee experiences a qualifying event on or before the date of Medicare entitlement, or after the expiration of the 18 month period after Medicare entitlement, both Employee and family members who are qualified beneficiaries are entitled to up to 18 months from the date of the qualifying event.

If the Employee’s Medicare entitlement follows an initial qualifying event (due to termination or reduction of hours worked) and would have resulted in a loss of coverage had it occurred before the initial qualifying event, then other family members who are qualified beneficiaries will be allowed to elect COBRA coverage up to 36 months from the date of the initial qualifying event.

Children Born To, or Placed for Adoption with the Covered Employee after the Qualifying Event

If, during the period of continuation coverage, a child is born to, adopted by or placed for adoption with the covered Employee and the covered Employee has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The covered Employee or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The covered Employee or a family member must notify the Plan Administrator within 30 days of the birth, adoption, or placement to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the Employee. (The 30-day period is the Plan’s normal enrollment window for newborn children, adopted children or children placed for adoption). If the covered Employee or family member fails to so notify the Plan Administrator in a timely fashion, the covered Employee will NOT be offered the option to elect COBRA coverage for the child.
Termination of COBRA before the End of Maximum Coverage Period

Continuation coverage of the Employee, Spouse, and/or Dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

1. The National Mutual Insurance Company no longer provides group health coverage to any of its Employees.
2. The premium for the qualified beneficiary’s COBRA coverage is not timely paid.
3. After electing COBRA, you (Employee, Spouse or Dependent child) become covered under another group health plan (as an Employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the "other plan" has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. Note that under Federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion, or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.
4. After electing COBRA, you (Employee, Spouse or Dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. If you (Employee, Spouse or Dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their Spouses or Dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

Other Information

If you (the Employee) or your qualified beneficiaries have any questions about this notice or COBRA, please contact the Plan Administrator at the address listed below. Also, please contact The National Mutual Insurance Company if you wish to receive the most recent copy of the Plan’s Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions, and limitations.

If your marital status changes, or a Dependent ceases to be a Dependent eligible for coverage under the Plan terms, or your or your Spouse’s address changes, you must immediately notify the Plan Administrator.

The National Mutual Insurance Company
Attn: Benefits
One Insurance Square
Celina, Ohio 45822
419-586-5181
USERRA

The following provisions are required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA):

Continuation of Coverage Due to Military Leave

If you are absent from work due to a leave for military service and were covered under this Plan prior to the leave, coverage for you and your Dependents may be continued for a period that is the lesser of twenty-four (24) months or a period that ends the day you fail to apply for or return to a position of employment. Coverage continued during the military service will be counted toward the maximum COBRA continuation period. The twenty-four (24) month period is measured from the date you leave work for military service.

If you are on military leave for less than thirty-one (31) days, your contribution for coverage will be the same as while you are actively at work. If your military leave extends for more than thirty-one (31) days, then you are required to pay the full cost of coverage.

Reinstatement of Coverage Following Military Leave

If you are reemployed following military leave, you will be covered under the same terms and conditions that would have been provided had you continued actively working.

Your coverage will be reinstated on your date of reemployment, provided the following conditions are met:

1. You have given advance written or verbal notice of the military leave to The National Mutual Insurance Company (advance notice to The National Mutual Insurance Company is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);
2. The cumulative length of the leave and all previous absences from employment do not exceed five (5) years;
3. Reemployment follows a release from military service under honorable conditions; and
4. You report to, or submit an application to The National Mutual Insurance Company as follows:
   a. On the first business day following completion of military service for a leave of thirty (30) days or less; or
   b. Within fourteen (14) days of completion of military service for a leave of thirty-one (31) days to one hundred-eighty (180) days; or
   c. Within ninety (90) days of completion of military service for a leave of more than one hundred-eighty days.

If you are Hospitalized for, or recovering from, an Illness or Injury when your military leave expires, you have two (2) years to apply for reemployment.

If you provide written notice of intent not to return to work after military leave, you are not entitled to reemployment benefits.

If the requirements for reemployment are satisfied, coverage will continue as though employment had not been interrupted by a military leave, even if you decline continued
coverage during the leave. No new waiting periods or preexisting condition limitation will apply to you or your Dependents. Credit will be given toward the preexisting conditions limitation for any time satisfied under the Plan from you or your Dependent’s original effective date. However, a waiting period preexisting condition limitation and/or plan exclusion may apply for Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during military service.

EFFECT OF MEDICARE ON THE PLAN

If a Covered Person is eligible for Medicare and incurs covered expenses for which benefits are payable under this Plan, then the Plan Administrator will determine if such coverage is Primary or Secondary to coverage provided by Medicare. Primary means that benefits payable under this Plan will be determined and paid without regard to Medicare. Secondary means that payments under the Plan will be reduced so that the total payable by Medicare and the Plan will not exceed 100% of the actual covered expense.

Coverage for a Covered Person will always be Primary if:

1. The Covered Person is an active employee or the spouse of an active employee;
or

2. The Covered Person is entitled to benefits under Medicare because of renal dialysis or kidney transplant. In this case coverage under this plan will be Primary only during the first 30 months of the period such person is so entitled; or

3. The Covered Person is under age 65 and has been receiving Social Security Disability Benefits for less than 2 years.

Coverage for a Covered Person will be Secondary if:

1. The Covered Person has been entitled to benefits under Medicare because of renal dialysis or kidney transplant for more than 30 months. In this case, coverage under this Plan will be Secondary only after the first 30 months of the period such person is so entitled;

The Plan Administrator will decide whether coverage is Primary or Secondary based on the status of the Covered Person on the date the covered expense is Incurred.

If a Covered Person does not enroll for coverage under Part A and Part B of Medicare or does not make due claim for Medicare benefits, the Plan Administrator will calculate benefits as if he were enrolled in both parts of Medicare and full claim for benefits had been made.

MEDICARE PART D COVERAGE

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.
However, if you drop or lose your current creditable prescription drug coverage, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current The National Mutual Insurance Company Group Health Plan drug coverage will not be affected. You can keep your current drug coverage and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current The National Mutual Insurance Company Group Health Plan coverage, be aware that you and your Dependents will not be able to get this coverage back until the next open enrollment.

You should also know that if you drop or lose your current coverage with The National Mutual Insurance Company Group Health Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.
DEFINITIONS

Ambulatory Surgical Facility - a facility, with an organized staff of Physicians, which:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- does not provide Inpatient accommodations; and
- is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Professional Other Provider.

Billed Charges - charges for all services and supplies that the Covered Person has received from the Provider, whether they are Covered Services or not.

Birthing Center - a facility which meets all of the following tests:

- It is primarily engaged in providing birthing services for low risk pregnancies;
- It is operated under the supervision of a doctor;
- It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;
- It has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year - the period that starts with the effective date on your identification card and ends on December 31st of such year. Each following Calendar Year shall start on January 1st of any year and end on December 31st of that year.

Centers of Excellence - a facility designated by the Plan to perform certain high cost/high risk procedures, such as organ transplants.

Certificate of Creditable Coverage - a certification of coverage to individuals who cease to be covered under a plan.

Child Support Performance and Incentive Act of 1998 (CSPIA) Information and Notification - requires a group health plan, insurance company, and HMO to honor a qualified medical child support order (QMCSO) submitted to the Plan and pay benefits to:

1. Any child who is an "alternate recipient" specified therein;
2. The child's custodial parent or guardian who incurs covered expenses on the child's behalf; or
3. An official of a state or political subdivision whose name and address has been substituted for that of any alternate payee in the order. This third alternative is effective for QMCSOs issued on or after August 5, 1997.
• If the Plan receives a court order to provide coverage for a qualified Employee’s Dependent child, the Plan Sponsor must notify the Employee and determine if the child is eligible for coverage. Eligibility determinations will be made in accordance with federal child support order laws and regulations. The Employee will be responsible for any required contributions.

• The coverage provided in accordance with a child support order will be effective as of the date of the child support order and subject to all provisions of the group plan. The coverage required by a child support order will cease on the earlier of the date the support order expires or the date the Dependent is enrolled for similar coverage. The Plan will not deny coverage or benefits because a person is eligible for other state or federal sponsored medical benefits.

• If covered expenses for a Dependent child are paid by a custodial parent or legal guardian who is not the covered Employee and/or Dependent, reimbursement must be made directly to the custodial parent or legal guardian rather than the covered Employee and/or Dependent. A custodial parent or legal guardian may also sign claim forms and assign Plan benefits.

Claims Administrator – an organization which has been retained by the Plan Administrator / Plan Sponsor to process healthcare claims and / or provide administrative services on behalf of the Plan. Administrator in this definition does not have the same meaning as the term “Plan Administrator” as used in the Employee Retirement Income Security Act of 1974 (ERISA).

Coinsurance - a dollar amount, as specified in the Schedule of Benefits, that you are required to pay toward Covered Services.

Complications of Pregnancy - a condition needing medical treatment before or after termination of pregnancy. The condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis, cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that can’t be classified as a distinct complication of pregnancy but are connected with the management of a difficult pregnancy. Also included are: Medically Necessary cesarean sections; terminated ectopic pregnancy; spontaneous termination that occurs during pregnancy in which a viable birth is impossible; hyperemesis gravidarum; and preeclampsia.

Confinement/Confined - the period starting with a Covered Person’s admission on an inpatient basis (more than 24 hours) to a Hospital or other licensed health care facility for treatment of an Illness or Injury. Confinement ends with the Covered Person’s discharge from the same Hospital or other facility. If the Covered Person is transferred to another Hospital or other facility for continued treatment of the same or related Illness or Injury, it’s still just one Confinement.

Consultant - a Physician or Professional Other Provider, as defined, who has special knowledge, training, and skill related to your Injury, Illness, or disease.

Convalescent Facility/Skilled Nursing Facility/Rehabilitation Facility

• A Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a Hospital, as defined; or

• An institution which fully meets all of the following:
a. It is operated in accordance with the applicable laws of the jurisdiction in which it is located;
b. It is under the supervision of a licensed Physician, or registered graduate nurse (R.N.) who is devoting full-time to such supervision;
c. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness;
d. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician;
e. It is authorized to administer medication to patients on the order of a duly licensed Physician;
f. It is not, other than incidentally, a home for the aged, the blind, the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill;
g. It is not a Hospital or part of a Hospital.

**Copay** - A cost sharing arrangement whereby a Covered Person pays a set amount to a provider for a specific service.

**Covered Person** - an eligible Employee or eligible Dependent who has been properly enrolled and is covered by the Plan.

**Covered Service** - a Provider's service or supply as described in this document for which benefits will be provided as listed in the Schedule of Benefits.

**Creditable Coverage** - coverage under any previous health plan, individual or group coverage, private or public, including Medicare and military coverage.

**Custodial Care** - care provided primarily for maintenance of the patient or care which is designed essentially to assist the patient in meeting his activities of daily living. This does not include care primarily provided for its therapeutic value in the treatment of an Illness, disease, bodily Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications not requiring the constant attention of trained medical personnel.

**Day Treatment Programs** - non residential programs for treatment of Substance Abuse, which are operated by certified inpatient and outpatient Substance Abuse Treatment Facilities, that provide case management, counseling, medical care, and therapies on a routine basis for a scheduled part of the day and a scheduled number of days per week; also known as partial Hospitalization.

**Dependent** - as defined in the Eligibility section of this booklet.

**Durable Medical Equipment** - an item which can withstand repeated use and is, as determined by the Plan, (a) primarily used to serve a medical purpose with respect to an Illness or Injury; (b) generally not useful to a person in the absence of an Illness or Injury; (c) appropriate for use in a Covered Person's home; and (d) prescribed by a Physician. All requirements of this definition must be satisfied before an item can be considered to be Durable Medical Equipment.

**Eligible Employee** - as defined in the Eligibility section of this booklet.

**Emergency Medical Care** - medical services provided by a Health Care Provider to treat a Covered Person's medical emergency. A medical emergency is the sudden and unexpected
onset of one or more acute conditions calling for medical services which the Covered Person receives right after the onset of such condition(s). For example, such an emergency includes heart attack, cardiovascular accident, poisoning, loss of consciousness or loss of breathing. These and other acute conditions are medical emergencies when all of the following are met, as determined by the Plan:

1. The Covered Person requires immediate medical care; and

2. The onset of the severe symptom(s) of the acute condition(s) is sudden and unexpected. The symptom(s) must be severe enough to cause a reasonably prudent person to seek medical care right away, no matter what time of day it is; and

3. Immediate care must be obtained (if it is not, it's not a medical emergency); and

4. A Health Care Provider's diagnosis of the symptom(s) indicates the condition(s) required immediate medical care.

Employee - Any common law employee of The National Mutual Insurance Company. The term “Employee” excludes any person who is not classified by The National Mutual Insurance Company on its payroll records as an Employee for purposes of federal income tax withholding. Employees do not include individuals classified as independent contractors, even if the classification is determined to be erroneous or is retroactively revised (such as by a governmental agency or court order). If a person who was excluded from the definition of Employee is later determined to have been misclassified, the person shall continue to be treated as a non-Employee for all periods prior to the date the classification of the person should be revised for purposes of the Plan.

Essential Health Benefits - is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental/Investigative - any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

1. The device drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug, or medicine is furnished;

2. Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility and the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.
Experimental or Investigative shall also mean: (a) any treatments, services or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expenses relating to transplant of non-human organs.

Health Care Provider - any person, institution or other entity licensed by the state in which he/she or it is located to provide treatment, services or supplies covered by the Plan to a Covered Person within the lawful scope of his/her license.

Hospice - an agency that provides counseling, medical services and may provide room and board to a terminally ill eligible individual and which meets all of the following:

- It has obtained any required state or governmental Certificate of Need approval;
- It provides service 24 hours a day, 7 days a week;
- It is under the direct supervision of a doctor;
- It has a nurse coordinator who is a registered nurse (R.N.);
- It has a social service coordinator who is licensed;
- It is an agency that has as its primary purpose the provision of Hospice services;
- It has a full-time administrator;
- It maintains written records of services provided to the patient; and
- It is licensed, if licensing is required.

Hospital - an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets all of the requirements set forth in (1.) or (2.) or (3.) below:

1. It is a Hospital accredited by the Joint Commission on Accreditation of Hospitals.
2. It is a Hospital, a Psychiatric Hospital, or a tuberculosis Hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.
3. It is an institution which fully meets all of the following:
   a. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians; and
   b. It continuously provides on the premises 24 hour-a-day nursing service by or under the supervision of registered graduate nurses; and
   c. It is operated continuously with organized facilities for operative surgery on the premises.

A Hospital does not include, as determined by the Plan: (a) a convalescent or extended care facility unit within or affiliated with the Hospital; (b) a clinic; (c) a nursing, rest or convalescent home or extended care facility; (d) an institution operated mainly for care of the aged or for treatment of Mental Illness or Substance Abuse; (e) a health resort, spa or sanitarium; or (f) a sub-acute care center.

Illness - any physical or mental sickness or disease which manifests treatable symptoms and which requires treatment of a Physician. This definition will also include pregnancy.

Incurred - a charge is considered Incurred on the date the Covered Person receives the service or supply for which the charge is made.
Injury - any accidental bodily damage or hurt sustained while the Covered Person is covered under the Plan and which requires treatment by a Physician. Damage caused by chewing is not an Injury.

Medically Necessary (or Medical Necessity) – Health care services, supplies or treatment that are required to identify or treat the illness or injury which a physician has diagnosed or reasonably suspects. To be medically necessary the service, supplies or treatment must be:

- consistent with the diagnosis and treatment of the patient's condition
- consistent with professionally recognized standards of health care;
- not solely for the convenience of the patient, physician or supplier; and
- performed in the least costly setting required by the patient's medical condition.

The fact that a physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria.

Mental Nervous Disorders - a condition diagnosed to be a Mental Illness and listed within diagnostic code numbers 290 to 302 and 306 to 319, inclusive of the International Classification of Diseases of the U.S. Department of Health and Human Services (ICD-9-CM, as amended or revised). Conditions included in the preceding diagnostic codes for which mental health treatment is received will be considered Mental Illness, regardless of the etiology of the patient's symptoms; i.e., even if symptoms are due to an organic (physical) cause, or are considered functional (non-physical) in origin.

Miscellaneous Hospital Expense - the regular Hospital charges (but not room and board, nursing services and ambulance services) covered under the Plan for care for an Illness or Injury requiring inpatient Hospitalization.

Non-Covered Charges - Billed Charges for services and supplies which are not Covered Services.

Non-Participating - the status of a Physician, Other Professional Provider, Hospital or Other Facility Provider that does not have a signed agreement with the Plan's PPO Network regarding payment for Covered Services.

Other Provider - the following entities which are licensed (where required) and provide their patients with Covered Services in exchange for compensation.

Other Professional Providers include the following:

- Dentist
- Doctor of Chiropractic Medicine
- Certified Registered Nurse Anesthetist (CRNA)
- Laboratory (must be Medicare approved)
- Licensed Mental Health and Substance Abuse Counselors
- Licensed Social Worker
- Midwife
- Nurse Practitioner
• Occupational Therapist
• Physician Assistant (PA)
• Physical Therapist
• Podiatrist
• Psychologist

Other Provider Facilities include the following institutions:

• Alcoholism Treatment Facility - a facility which mainly provides detoxification and rehabilitation treatment for Alcoholism.
• Dialysis Facility - a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
• Drug Abuse Treatment Facility - a facility which provides detoxification and rehabilitation treatment for Drug Abuse.
• Home Health Care Agency - a facility which:
  a. provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
  b. is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
• Psychiatric Hospital - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the Inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Participant – an eligible Employee or Dependent who has selected and is participating in the Plan.

Pharmacy - an "Other Professional Provider" which is a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law.

Physician - a person who received a degree in medicine and is a medical doctor or surgeon licensed by the state in which he/she is located and provides services while he/she is acting within the lawful scope of his/her license. When the Plan is required by law to cover the services of any other licensed medical professional a Physician also includes such other licensed medical professional, for example, a chiropodist, podiatrist, dentist, or chiropractor who: (a) is acting within the lawful scope of his/her license; (b) performs a service which is covered under the Plan.


Plan Administrator – Same entity as Plan Sponsor.

Plan Documents – the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this summary of benefits.

PPACA – The Patient Protection and Affordable Care Act which was passed by Congress in 2010, also referred to as the Health Care Reform Act.

PPO Network Provider - a Physician, Other Professional Provider, contracting Hospital or contracting Other Facility Provider which is included in a limited panel of Providers as designated by the Participating Network(s) and for which the greatest benefit will be payable when one of these Providers is used.

Pre-Admission Tests - tests performed on you or your Dependent prior to Confinement as an inpatient, provided:

1. such tests are related to the performance of scheduled surgery;
2. such tests have been ordered by a duly qualified Physician after a Condition requiring such surgery has been diagnosed and Hospital admission for such surgery has been requested by the Physician; and
3. you or your Dependent are subsequently admitted to the Hospital, or the Confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in your or your Dependent's condition which precludes the surgery.

Preventive Care – As used in the SPD refer to Routine immunizations and other evidence-based items or services that are United States Preventive Services Task Force (USPSTF) A or B recommendations or recommendations from other bodies such as the American Academy of Pediatrics.

Prior Health Plan - the previous plan of medical insurance coverage.

Protected Health Information (PHI) – individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearing house and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

Psychologist - only a person who specializes in clinical psychology and fulfills the requirements specified in item (1) or (2) below, whichever is applicable:

1. A person who is licensed or certified as a Psychologist by the appropriate governmental authority having jurisdiction over such licensure or certification, as the case may be, in the jurisdiction where such person renders service to you or your Dependent.
2. A person who is a Member or Fellow of the American Psychological Association, if there is no licensure or certification in the jurisdiction where such person renders service to you or your Dependent.

Qualified Medical Child Support Orders - the term “Qualified Medical Child Support Order”, (QMCSO), means a Medical Child Support Order, (MCSO), which creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to receive benefits for which a Participant or beneficiary is eligible under the Plan. The term “Medical Child Support Order” means any court issued judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which provides
The National Mutual Insurance Company

for child support with respect to a child of a Participant under the Plan or provides for health coverage to such a child pursuant to a state domestic relations law and relates to benefits under the Plan.

The term "Alternate Recipient" means any child of a Participant who is recognized under a MCSO as having a right to enrollment under the Plan with respect to such Participant.

A person who is an Alternate Recipient under a QMCSO shall be considered a beneficiary under the Plan.

Any payment for benefits by the Plan, pursuant to a MCSO in reimbursement for expense paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian, shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

Upon receipt of the MCSO, the Plan shall immediately determine if such child is qualified. The MCSO must include the following to be considered a QMCSO:

1. The name and last known mailing address of the Participant;
2. The name and address of each Alternate Recipient;
3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which such coverage is to be determined;
4. The period for which coverage must be provided; and
5. Each Plan to which the order applies.

After determining whether the MCSO is or is not a QMCSO, the Claims Administrator shall notify all affected parties (including the Alternate Recipient) in writing. They will be given the opportunity to represent themselves or to designate a representative to receive all communications. The determination as to whether the QMCSO Participant is qualified or not, and whether coverage will be extended, will be provided in writing within 30 days of receipt of all requested documentation.

The National Mutual Insurance Company shall not disenroll or eliminate coverage on such child until:

1. Satisfactory written evidence is provided that the court order or administrative order is no longer effective;
2. Satisfactory written evidence is provided that comparable coverage through another Plan will take effect no later than the disenrollment date; or
3. The National Mutual Insurance Company eliminates family coverage for all Participants.

Changes made in order to provide benefits for any Dependent pursuant to a QMCSO as provided by ERISA 609 (a) (A) (I) shall be made any time, irrespective of the normal enrollment dates, as required by the Revenue Reconciliation Act of 1993.

If it is determined that the MCSO is a QMCSO, thereafter, the Alternate Recipient, for the appropriate period, shall be treated as a beneficiary under the Plan.

Benefits shall be provided in accordance with the applicable requirements of any QMCSO. However, the QMCSO shall not cause the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan.
Reasonable and Customary - the term "Reasonable and Customary" refers to the designation of a charge as being the usual charge made by a Physician or other Provider of services and supplies, medication or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "Area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill or expertise. Except where noted otherwise, if a PPO is utilized, the PPO allowance may become R&C for services rendered by a PPO Provider when the contracted rates exceed the Reasonable and Customary charge.

Recovered / Recovery - monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or Illness whether or not said losses reflect medical or dental charges covered by this Plan.

Refund - repayment to this Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Illness.

Skilled Nursing Care - care furnished on a Physician's orders which require the skill of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

1. Minimal custodial, ambulatory, or part-time care; or

2. Treatment for mental Illness, or pulmonary tuberculosis.

Spouse – your legal Spouse (marriage between a man and a woman), provided you are not legally separated.

Subrogation - this Plan's rights to pursue the Covered Person's claims for medical or dental charges against the other person.
STATEMENT OF ERISA RIGHTS

As a Participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

Receive Information About Your Plan and Benefits

i. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

ii. Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

iii. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

iv. A certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Group Health Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administration.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (i.e. finds your claim is frivolous).
If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. The nearest EBSA Office is Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Ft. Wright, KY 41011-2664.

Patient Protection and Affordable Care Act of 2010

On the Effective date of this Summary Plan Description, certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010 (PPACA).

Grandfathered Health Plan Disclosure

The National Mutual Insurance Company 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 this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, 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, for example, 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 the Plan Administrator at The National Mutual Insurance Company, One Insurance Square, Celina, Ohio 45822. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at www.healthreform.gov. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Lifetime Dollar Limits

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan’s terms, and that Plan is still in effect, you should have received a notice that the lifetime dollar limit no longer applies and an opportunity to enroll or be reinstated under your Plan. Covered Persons who are eligible for this enrollment opportunity are treated as special enrollees.

Annual Dollar Limits

Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. You Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits.
The dollar amount of any lifetime limit that was in effect as of March 23, 2010, is your Plan's benefit period maximum for Essential Health Benefits, provided it is no less than $750,000.

Your Plan has an Unlimited Lifetime Maximum on Benefits Payable per individual.

Any other annual dollar limits on Essential Health Benefits that may have existed are deleted.

GENERAL PLAN INFORMATION

ERISA REQUIREMENT

Plan Name: The National Mutual Insurance Company Employee Group Health Plan

Plan Sponsor: The National Mutual Insurance Company
One Insurance Square
Celina, Ohio 45822
419-586-5181

Employer Tax I.D. No.: 34-4312510

Claims Administrator: Mutual Health Services
3636 Copley Road
P.O. Box 4138
Akron, Ohio 44321
(330) 666-0337
1-800-367-3762

Plan Number: 501

Type of Plan: Self-Funded Employee Benefit Plan - a Group Health Plan

Plan Year Ends: December 31st

Statutory Agent for Service of Legal Process: The Plan Sponsor named above