

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

(For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (the "Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (**regardless of where the policyholder lived when the policy was issued**)
- Residents of other states, ONLY if the following conditions are met:
 1. The policyholder has a policy with a company domiciled in Texas;
 2. The policyholder's state of residence has a similar guaranty association; and
 3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, and \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on any single life; or
- Death benefits up to a total of \$300,000 under one or more policies on any single life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of \$250,000 under one or more policies owned by one life.

Group Annuities:

- Present value of allocated benefits up to a \$250,000 on any one life; or
- Present value of unallocated benefits up to a \$5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov

STANDARD INSURANCE COMPANY

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Standard Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Customer Service

For Life Benefits Toll-free: 1(800)628-8600

For Disability Benefits Toll-free: 1(800)-368-1135

Online: <https://www.standard.com/individual/contact-us>

Mail: PO Box 711, Portland, Oregon 97207

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Standard Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Customer Service

Teléfono gratuito: For Life Benefits 1(800)628-8600

For Disability Benefits Teléfono gratuito: 1(800)368-1135

En línea: <https://www.standard.com/individual/contact-us>

Dirección postal: PO Box 711, Portland, Oregon 97207

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE

Policyholder:	Waller Independent School District
Group Policy Number:	171601-E
Group Policy Effective Date:	September 1, 2023
State of Issue:	Texas

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of the Group Policy. If your insurance is changed by an amendment to the Group Policy, we will provide the Policyholder or Employer with a revised Certificate or other notice that will be available to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

Your Certificate describes the insurance under the Group Policy. Please read your Certificate carefully.

THIS CERTIFICATE IS ISSUED UNDER A LIMITED BENEFIT POLICY THAT PROVIDES HOSPITAL INDEMNITY BENEFITS. THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE").

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

STANDARD INSURANCE COMPANY
By



President and CEO

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COVERAGE FEATURES

Employer(s)

Waller Independent School District

Member

You are a Member if you are all of the following:

- A regular employee of the Employer working in the United States.
- Actively At Work at least 20 hours each week.
- A citizen or resident of the United States.

You are not a Member if you are:

- A temporary or seasonal employee.
- A full time member of the armed forces of any country.
- A leased employee.
- An independent contractor.

Class(es)

All Members

Eligibility Waiting Period

If you are a Member on the Group Policy Effective Date, you are eligible on the first day of the calendar month following the date you become a Member.

If you become a Member after the Group Policy Effective Date, you are eligible on the first day of the calendar month following the date you become a Member.

If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, your Eligibility Waiting Period is waived on the effective date of your Employer's coverage under the Group Policy.

Premium Contributions

For you and your Dependents: **Contributory**

Contributory means you pay all or part of the premium for insurance.

Table Of Hospital Indemnity Insurance Amounts

All benefits are based on a per day schedule.

Hospitalization Benefits

Daily Critical Care Unit Confinement Benefit	\$150 per day
Daily Hospital Confinement Benefit	\$150 per day
Hospital Admission Benefit	\$2,000 per day

Additional Benefits

Health Maintenance Screening Benefit \$50 per day

Additional Features

Reinstatement

Continuity of Coverage

Waiver of Premium

Continuation of Insurance (Portability) for the Member

ELIGIBILITY AND ENROLLMENT

Becoming Insured

To become insured you must:

- Be a Member.
- Complete your Eligibility Waiting Period.
- Meet the requirements shown in **When Your Insurance Becomes Effective** and **Active Work Requirement**.

When Your Insurance Becomes Effective

The **Coverage Features** states whether insurance is Contributory or Noncontributory. Subject to the **Active Work Requirement**, your insurance becomes effective as follows:

Contributory Insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance becomes effective on:

- The date you become eligible if you apply on or before that date.
- The date you apply if you apply within 31 day(s) after you become eligible.
- The beginning of the next plan year following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
 - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
 - The date you apply if you apply within 31 day(s) of the Family Status Change.
 - The beginning of the next plan year following the Annual Enrollment Period if you apply for the Family Status Change during the Annual Enrollment Period.

Annual Enrollment Period means the period designated each year by your Employer when you may apply for insurance or change insurance elections.

Changes in Your Insurance

You may apply in writing for any increase in your insurance.

Subject to the **Active Work Requirement**, increases in your insurance becomes effective as follows:

Increases become effective on the latest of:

- The date you apply for the increase.
- The beginning of the next plan year following the Annual Enrollment Period during which you apply for the increase.
- The date of your Family Status Change.

Decreases in insurance amounts becomes effective on:

- The beginning of the next plan year following the Annual Enrollment Period during which you requested the decrease.
- The first day of the calendar month coinciding with or next following the date the Policyholder or Employer receives your written request for the decrease.

Active Work Requirement

If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or increase in your insurance under the Group Policy, such insurance or increase in your insurance will not become effective until the day after you complete 1 full day(s) of Active Work as an eligible Member.

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the **Active Work Requirement** if you meet all of the requirements shown below:

- You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day.
- You were Actively At Work on your last scheduled work day before the date of your absence.
- You were capable of Active Work on the day before the scheduled effective date of your insurance or increase in your insurance.

When Your Insurance Ends

Insurance ends automatically on the earliest of the following:

- For Contributory insurance, the date you notify your Policyholder or your Employer in writing that coverage is to be terminated.
- The date the last period ends for which the premium was paid for your insurance.
- The date the Group Policy terminates unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The first day of the calendar month following the date your employment terminates unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued with payment of premium:
 - During the first 60 day(s) of a temporary or indefinite administrative leave of absence or sick leave.
 - During any other scheduled leave of absence approved by your Employer in advance and in writing and lasting not more than 60 day(s).
 - During a leave of absence which is required by the federal or a state-mandated family or medical leave act or law.

CHILD INSURANCE

Eligibility for Child Insurance

You become eligible to insure your Child(ren) on the later of:

- The date you become eligible for insurance if you have a Child on that date.
- The date you first acquire a Child, if you are insured on that date.

A Member may not be insured as both a Member and a Child. A Child may not be insured by more than one Member.

When Child Insurance Becomes Effective

The **Coverage Features** states whether your Child insurance is Contributory or Noncontributory. You must apply in writing for Contributory Child insurance and agree to pay premiums.

Contributory Child insurance becomes effective the latest of:

- The date your insurance becomes effective if you apply on or before that date to insure your Child.
- The date you apply to insure your Child.
- The beginning of the next plan year following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
 - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
 - The date you apply if you apply within 31 day(s) of the Family Status Change.
 - The beginning of the next plan year following the Annual Enrollment Period if you apply for the Family Status Change during the Annual Enrollment Period.

For Contributory Child insurance, if you do not have Child insurance at the time you acquire a newborn or adopted or foster Child, that Child is automatically insured for 31 days from the moment of birth or placement, subject to the hospital confinement exclusion for newborns. However, you must apply in writing and pay premium back to the date of birth or placement within 31 days for Child insurance to continue. If your application is received after that 31 days, your automatic Child insurance under this provision ends on the first day after the 31 day period. This provision does not apply to you if you have an existing Child and you previously declined to enroll in Child insurance.

Changes in Child Insurance

You may apply in writing for any increase in your Child insurance.

Increases in your Child insurance become effective on the date of your insurance increase.

A decrease in your Child insurance because of a decrease in your insurance becomes effective on the date of your insurance decrease.

When Child Insurance Ends

Your insurance for a Child ends automatically on the earliest of:

- The date your insurance ends unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date Child insurance terminates under the Group Policy unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date a Child ceases to meet the definition of Child.
- The date the last period ends for which the premium was paid for your Child insurance.
- The date the Group Policy terminates unless Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

SPOUSE INSURANCE

Eligibility for Spouse Insurance

You become eligible to insure your Spouse on the later of:

- The date you become eligible for insurance if you have a Spouse on that date.
- The date you acquire a Spouse if you are insured on that date.

To become insured your Spouse must be gainfully employed or capable of performing the material duties of an occupation. A Member may not be insured as both a Member and a Spouse.

When Spouse Insurance Becomes Effective

The **Coverage Features** states whether your Spouse insurance is Contributory or Noncontributory. You must apply in writing for Contributory Spouse insurance and agree to pay premiums. Subject to your Spouse being gainfully employed or capable of performing the material duties of an occupation, your Spouse insurance becomes effective as follows:

Contributory Spouse Insurance becomes effective on the later of:

- The date your insurance becomes effective if you apply on or before that date to insure your Spouse.
- The date you apply to insure your Spouse.
- The beginning of the next plan year following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
 - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
 - The date you apply if you apply within 31 day(s) of a Family Status change.
 - The beginning of the next plan year following the Annual Enrollment Period if you apply for the Family Status Change during the Annual Enrollment Period.

Changes in Spouse Insurance

You may apply in writing for any increase in your Spouse insurance. Subject to your Spouse being gainfully employed or capable of performing the material duties of an occupation, increases in your Spouse insurance becomes effective as follows:

Increases in your Spouse insurance become effective on the date of your insurance increase.

A decrease in your Spouse insurance because of a decrease in your insurance becomes effective on the date of your insurance decrease.

When Spouse Insurance Ends

Your insurance for a Spouse ends automatically on the earliest of:

- The date your insurance ends unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date Spouse insurance terminates under the Group Policy unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date a Spouse ceases to meet the definition of Spouse.
- The date the last period ends for which the premium was paid for your Spouse insurance.
- The date the Group Policy terminates, or the date your Employer's coverage under the Group Policy terminates unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

HOSPITAL INDEMNITY BENEFITS

Insuring Clause

If you or your Dependent incur a Loss or meet the requirements for the Health Maintenance Screening Benefit while insured under the Group Policy, we will pay benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

Hospitalization Benefits

Daily Critical Care Unit Confinement Benefit

We will pay a Daily Critical Care Confinement Unit Benefit for the days you or your Dependent meet the following requirements:

- Confined to a Critical Care Unit of a Hospital due to a Sickness.
- For an Injury, Confinement in a Critical Care Unit occurs within 90 days of the Injury.

We will pay a Daily Critical Care Unit Confinement Benefit for up to 15 days per Confinement per insured person.

If you or your Dependent become Confined to a Critical Care Unit within 30 days for the same or related Loss, we will treat the period of Confinement as a continuation of the prior Confinement, although no benefits will be payable for any period of non-Confinement. If more than 30 days have passed between periods of Confinement for the same or related Loss, the subsequent Confinement will be treated as a separate period.

Only one Daily Critical Care Unit Confinement Benefit is payable at a time, even if Confinement is caused by more than one Loss.

Daily Hospital Confinement Benefit

We will pay a Daily Hospital Confinement Benefit for the days you or your Dependent meet the following requirements:

- Confined to a Hospital due to a Sickness.
- For an Injury, Confinement occurs within 365 days of the Injury.

We will pay a Daily Hospital Confinement Benefit for up to 30 days per Confinement per insured person.

If you or your Dependent become Confined to a Hospital within 30 days for the same or related Loss, we will treat the period of Confinement as a continuation of the prior Confinement, although no benefits will be payable for any period of non-Confinement. If more than 30 days have passed between periods of Confinement for the same or related Loss, the subsequent Confinement will be treated as a separate period.

Only one Daily Hospital Confinement Benefit is payable at a time, even if Confinement is caused by more than one Loss.

Hospital Admission Benefit

We will pay a Hospital Admission Benefit if you or your Dependent meet the following requirements:

- Admitted by a Physician to a Hospital due to a Loss.
- For an Injury, Admission occurs within 90 days of the Injury.

We will pay a Hospital Admission Benefit for the day of Admission. We will pay a Hospital Admission Benefit for up to 1 day(s) per insured person per Calendar Year.

If you or your Dependent are Admitted to a Hospital within 30 days of a previous Admission for the same or related Loss, we will not pay another Hospital Admission Benefit.

Additional Benefits

Health Maintenance Screening Benefit

We will pay a Health Maintenance Screening Benefit if you or your Dependent meet the following requirements:

- A Health Maintenance Screening Procedure is performed.

Health Maintenance Screening Procedures are limited to the following:

- Abdominal aortic aneurysm ultrasound.

- Ankle Brachial Index (ABI) screening for peripheral vascular disease.
- Biopsies for cancer.
- Bone density screening.
- Breast ultrasound.
- Cancer antigen 125 blood test for ovarian cancer (CA 125).
- Cancer antigen 15-3 test for breast cancer (CA 15-3).
- Carcinoembryonic antigen blood test for colon cancer (CEA).
- Colonoscopy.
- Complete Blood Count (CBC).
- Comprehensive Metabolic Panel (CMP).
- Electrocardiogram (EKG).
- Hemocult stool analysis.
- Hemoglobin AIC.
- Human Papillomavirus (HPV) vaccination.
- Lipid panel.
- Mammography.
- Pap smears or thin prep pap test.
- Prostate specific antigen (PSA) test.
- Stress test on a bicycle or treadmill.
- Mental health assessments, including but not limited to, PHQ-9, Beck's Depression Inventory, Hamilton's Depression Rating Scale.
- Novel infectious disease testing, including testing for antibodies related to novel infectious diseases.

We will pay a Health Screening Maintenance Benefit 1 day(s) per insured person per Calendar Year.

EXCLUSIONS AND LIMITATIONS

Exclusions

Benefits are not payable if an Injury or Sickness is caused or contributed to by any of the following:

- War or act of War. War means declared or undeclared war, whether civil or international, insurrection, and any substantial armed conflict between organized forces of a military nature.
- Attempted suicide or other intentionally self-inflicted injury, while sane or insane.
- Committing or attempting to commit an assault, a felony or act of terrorism, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing official duties.
- The voluntary use or consumption of any poison, chemical compound, drug, or alcohol in excess of the legal limit in the state in which the Injury occurred, unless used or consumed according to the directions of a Health Care Provider. This exclusion does not apply to a Sickness.
- Travel or flight in or on any aircraft; except:
 - As a fare-paying passenger on a regularly scheduled commercial flight.

- As a passenger or pilot in the Policyholder's or Employer's aircraft while flying on the Policyholder's or Employer's business provided:
 - The aircraft has a valid U.S. airworthiness certificate (or foreign equivalent).
 - The pilot has a valid pilot's certificate with a non-student rating authorizing him or her to fly the aircraft.
- Dental care or dental procedures, unless treatment is the result of an Injury.
- Routine newborn nursing or well-baby care.
- Hospital Confinement of a newborn Child following the Child's birth unless the Confinement is as a result of an Injury or Sickness.
- Riding in or driving any automobile in a race, stunt show, or speed test.
- Surgery or other procedure which is directed at improving your or your Dependent's appearance, unless such surgery or procedure is necessary to correct a deformity or to restore bodily function resulting from an Injury or Sickness. This exclusion does not apply to a gender affirmation procedure.
- Any Injury or Sickness which arises out of or in the course of your or your Dependent's incarceration in a jail, penal or correctional institution.

ADDITIONAL FEATURES

Reinstatement

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

- If your insurance ends because you cease to be a Member and if you become a Member again within 90 day(s) the Eligibility Waiting Period will be waived.
- If your insurance ends because you fail to make the required premium contribution, you and your Dependent must provide Evidence Of Insurability to become insured again.
- If you ceased to be a Member under the Group Policy and continued insurance under the **Continuation of Insurance (Portability) for the Member** provision and you become a Member again within 90 day(s), your insurance will be for the coverage and amount which you continued under the **Continuation of Insurance (Portability) for the Member** provision the day before you become a new Member.

In no event will insurance be retroactive.

Continuity of Coverage

Waiver of **Active Work Requirement**

If you were insured under the Prior Plan on the day before the effective date of the Employer's coverage under the Group Policy, you can become insured on the effective date of your Employer's coverage without meeting the **Active Work Requirement**. See the **Active Work Requirement**.

Waiver of Premium

Your insurance will continue without payment of premiums if you are Confined in a Hospital for 30 or more consecutive days.

We will waive payment of premium for your insurance from the 31st day of your Confinement until the last day of the month of your Confinement.

Continuation of Insurance (Portability) for the Member

Eligibility for the Member

You are eligible to continue your or your Dependent's insurance on the date one of the following events occurs:

- Your employment terminates with your Employer.
- The Group Policy terminates.
- Your insurance ends because you are no longer a Member.

You are not eligible to continue insurance under this provision if:

- You are disabled.
- You are age 80 or older.

Application, Amount of Insurance, and Premium Payment

You must apply in writing and pay the first premium to us within 31 days after the date you become eligible. Your and your Dependent's continued insurance will be the same insurance provided under the Group Policy on the day before you become eligible under this **Continuation of Insurance (Portability) for the Member**. You may decrease the insurance, but cannot increase the insurance.

You will be directly billed for all premiums due if you have applied for and been approved for continuation of insurance under this provision. If premium is not paid on or before the Premium Due Date stated below it may be paid during the Grace Period as stated below. Your or your Dependent's insurance will remain in force during the Grace Period. You are liable for premium for insurance during the Grace Period.

The Premium Due Date is the first day of each calendar month.

The Grace Period is 60 days from the Premium Due Date.

When Insurance Ends

Insurance continued under this provision ends automatically on the earliest of:

- The date the last period ends for which you made the premium payment.
- The date you die.
- The date you become a full-time member of the armed forces of any country.
- With respect to your Child's insurance, the date the Child ceases to meet the definition of Child.
- The date you reach age 80.
- The date you are sentenced by a court for any reason to a penal or correctional institution.
- With respect to your Spouse's insurance, the date the Spouse ceases to meet the definition of Spouse.
- With respect to coverage for your Dependent, the date your Dependent is sentenced by a court for any reason to a penal or correctional institution.
- The date you become insured again as a Member under the Group Policy.

Once insurance continued under this provision ends it cannot be reinstated. Except as provided above, insurance continued under this provision is subject to all other terms of the Group Policy.

CLAIMS AND BENEFIT PAYMENT

Filing a Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us.

Time Limits on Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the Loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90 day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

Proof Of Loss

Proof Of Loss means written proof that a Loss or entitlement to a Health Maintenance Screening Benefit occurred:

- For which the Group Policy provides benefits.
- Which is not subject to any exclusions or limitations.
- Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be paid until we receive Proof Of Loss satisfactory to us.

Investigation of Claim

We reserve the right to investigate a claim at any time at our expense, including an examination conducted by specialists of our choice. In case of death, we have the right and opportunity to request an autopsy, except where prohibited by law.

Notice of Decision on Claim

We will evaluate a claim for benefits promptly after we receive it. Within 60 days after we receive the claim we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 60 days.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension and (b) when we expect to decide the claim.

If we deny any part of the claim, we will send the claimant a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- A description of any additional information needed to support the claim.
- Information concerning the claimant's right to a review of our decision.

Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial of the claim.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. With respect to all claims, within 45 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension and (b) when we expect to decide the claim on review.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

If we deny any part of the claim on review, the claimant will receive a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

Time of Payment

We will pay benefits within 30 working days after Proof Of Loss is satisfied.

Payment of Benefits

Benefits will be paid to you. Any benefits remaining unpaid at your death will be paid as shown below:

Benefits will be paid in equal shares to the first surviving class of the classes below.

- Your Spouse.
- Your children.
- Your parents.
- Your brothers and sisters.
- Your estate.

Reimbursement

We reserve the right to recover any benefits that you or your Dependent, a claimant or a beneficiary were paid but not entitled to under the terms of the Group Policy, state, or federal law.

You or your Dependent, a claimant or beneficiary must reimburse us in full. We will determine the method by which repayment is to be paid.

Unpaid Premium

Any unpaid premium due for your or your Dependent's Hospital Indemnity Insurance under the Group Policy may be recovered by us. Any Hospital Indemnity Benefits payable to you, a claimant, a beneficiary or legal representative will be applied to reduce the amount of any unpaid premiums prior to paying you or your Dependent, a claimant, a beneficiary or a legal representative.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy may not be assigned.

Time Limits on Legal Actions

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than three years after the earlier of:

- The date we receive Proof Of Loss.
- The time within which Proof Of Loss is required to be given.

Incontestability of Insurance

Any statement made to obtain insurance or to increase insurance is a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

- The insurance would not have been approved if we had known the truth.
- We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the claim, unless it was a fraudulent misrepresentation.

Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

- Cause a person to become insured.
- Invalidate insurance under the Group Policy otherwise validly in force.
- Continue insurance under the Group Policy otherwise validly terminated.

Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of us. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

Misstatement of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct age.
- The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

DEFINITIONS

Admitted or Admission

A stay at a Hospital or Critical Care Unit for at least 20 consecutive hours for examination by a Physician for diagnosis or treatment of a Loss.

Ambulatory Surgical Center

A licensed facility that is mainly engaged in performing Outpatient surgery. An Ambulatory Surgical Center must:

- Be staffed by Physicians and nurses under the supervision of a Physician.
- Have permanent operating and recovery rooms.

- Be capable of administering anesthesia by a licensed anesthesiologist or licensed nurse anesthetist.
- Be staffed and equipped to give emergency care.
- Have written back-up arrangements with a local Hospital for emergency care.

Calendar Year

The period from January 1 through December 31 of the same year.

Child or Children

Child or Children means one of the following:

- Your child from live birth until age 26.
- Your adopted child until age 26.
- Your stepchild, foster child, dependent grandchild, and the child of your Spouse if living in your home until age 26.
- A child living in your home for whom you are the court appointed legal guardian until age 26.
- Your child, stepchild, foster child, dependent grandchild, and the child of your Spouse who is continuously incapable of self-sustaining employment because of mental or physical handicap; and chiefly dependent upon you for support and maintenance or institutionalized because of mental or physical handicap.

Child does not include a person who is eligible for insurance as a Member. A Child does not include a full-time member of the armed forces of any country.

Confinement or Confined

You or your Dependent are admitted to a Hospital as an Inpatient for diagnosis and treatment of a Loss for a period of no less than 20 consecutive hours the first day and overnight for subsequent days. Hours spent in an Emergency Room immediately prior to being Admitted to a Hospital will count toward the required 20 consecutive hours.

Critical Care Unit (CCU)

Critical Care Unit (CCU) means a specified area within a Hospital that is restricted to patients who are critically ill or injured and require intensive comprehensive observation and care. This area must:

- Be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
- Be permanently equipped with special lifesaving equipment for the care of the critically ill or injured.
- Be under close observation by a specially trained nursing staff assigned exclusively to the unit on a 24-hour basis.
- Have a Physician assigned on a full-time basis.

Dependent(s)

Your Spouse or Child.

Eligibility Waiting Period

The period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features**.

Emergency Room

A specified area within a Hospital that is staffed and equipped for emergency patient care. This area must:

- Be supervised with treatment provided by Physicians.

- Provide care seven days per week, 24 hours per day.

Employer

An employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Evidence Of Insurability

You or your Dependent must:

- Complete and sign our medical history statement.
- If required by us, sign our form authorizing us to obtain information about the applicant's health.
- Undergo a physical examination, if required by us, which may include blood testing.
- Provide any additional information about the applicant's insurability that we may reasonably require.

Family Status Change

Family Status Change means any of the following events:

- Your marriage or divorce or dissolution of your Civil Union or Domestic Partner relationship.
- The birth of your Child.
- The adoption of a Child by you.
- The death of your Dependent.
- The commencement or termination of your Spouse's employment.
- A change in employment from full-time to part-time by your Spouse.
- The loss of hospital indemnity insurance through your Spouse's employment.

Group Policy

The group hospital indemnity insurance policy issued by us to the Policyholder and identified by the Group Policy Number, the Policyholder's attached application, group hospital indemnity insurance certificates with the same Group Policy Number, and any amendments to the policy or certificates.

Health Care Provider

A Physician, Nurse Practitioner, or Physician Assistant.

Health Service Facility or Health Service Facilities

Health Service Facility or Facilities means one of the following:

- A Rehabilitation Facility.
- A nursing or convalescent home.
- A long term nursing unit or geriatrics ward.
- A Skilled Nursing Facility.
- An Ambulatory Surgical Center.
- An Urgent Care Facility.
- An assisted living facility.
- A hospice care facility.
- Health Care Provider office or clinic.

Hospital

A legally operated facility providing full-time medical care and treatment under the direction of a full-time staff of licensed Physicians. Hospital does not include Health Service Facilities.

Injury or Injuries

Damage inflicted on your or your Dependent's body by an external force that occurs after you or your Dependent are insured under the Group Policy.

Inpatient

A person who has been Admitted to a Hospital or Critical Care Unit and is a registered bed patient and for which a charge is incurred for room and board or observation.

Loss

An Injury or Sickness that is not excluded by name or specific description. Injuries must occur after insurance becomes effective.

Nurse Practitioner (advanced practice registered nurse)

An individual who is licensed by the state as a nurse practitioner to practice medicine under the supervision of a Physician and acting within the scope of the license. Nurse Practitioner does not include you or your Spouse or the brother, sister, parent or child of either you or your Spouse.

Outpatient

A treatment in a Hospital or other Health Service Facility for which a stay is not required and no charge is incurred for room and board or observation.

Physician

An individual who is licensed by the state as an M.D. or D.O. acting within the scope of the license. Physician does not include you or your Spouse or the brother, sister, parent or child of either you or your Spouse.

Physician Assistant

An individual who is licensed by the state as a physician assistant to practice medicine under the supervision of a Physician and acting within the scope of the license. Physician Assistant does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Pregnancy

Your or your Spouse's pregnancy, childbirth, or related medical conditions, including complications of pregnancy. Pregnancy is treated as a Sickness under the Group Policy.

Prior Plan

A hospital indemnity insurance plan which is replaced by coverage under the Group Policy and which is the Policyholder's group hospital indemnity insurance plan in effect on the day before the effective date of the Group Policy.

Rehabilitation Facility

A licensed facility that provides skilled care, intermediate care, intermingled care, custodial care or rehabilitation care services on an Inpatient basis as an alternative to a Hospital. Rehabilitation care services consist of the combined use of medical, social, education, and vocational services to enable a patient disabled by an Injury or Sickness to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. A Rehabilitation Facility does not include:

- A nursing or convalescent home.
- A Skilled Nursing Facility.

- A rest home for the aged.
- A hospice care facility.
- An assisted living facility.
- Chemical dependency treatment facility.
- Mental health treatment facility.

Sickness

Your or your Dependent's sickness, illness, or disease.

Skilled Nursing Facility

An Inpatient healthcare facility with the staff and equipment to provide skilled care, rehabilitation and other related health services to patients who need nursing care, but do not require a stay in a Hospital.

Spouse

Spouse means:

- A person to whom you are legally married.
- A person who is party to a Civil Union with you. Civil Union means a civil union established according to applicable law.
- Your Domestic Partner. Domestic Partner means an individual with whom you have established a domestic partnership in accordance with the laws or regulations of a jurisdiction that recognizes domestic partnerships; or an individual you have identified as a domestic partner under your Employer's domestic partnership policy, if applicable.

Spouse does not include a full-time member of the armed forces of any country.

Urgent Care Facility

A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short term urgent medical care, without an appointment.