

**NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
4441 SIX FORKS RD STE 106-153
Raleigh, North Carolina, 27609-5729

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
- They acquired rights to received payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulation issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

- (1) The guaranty association cannot pay more than the insurance company would owe under a policy or contract.
- (2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
- (3) The guaranty association will pay a maximum of \$500,000 with respect to a health benefit plan.
- (4) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.
- (5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

**REQUIRED NORTH CAROLINA NOTICE
REGARDING WILLFUL NONPAYMENT OF PREMIUM**

To Our North Carolina Participating Employers:

Under North Carolina General Statute Section 58-50-45, we are required to give you the following notice:

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

STANDARD INSURANCE COMPANY

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

GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE

Policyholder:	Guilford County Schools
Group Policy Number:	169386-D
Group Policy Effective Date:	January 1, 2024
State of Issue:	North Carolina

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").

Important Cancellation Information: Please read the provision entitled "When Your Insurance Ends" and "When Child Insurance Ends" and "When Spouse Insurance Ends". Please read your Certificate carefully.

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.

STANDARD INSURANCE COMPANY

By



President and CEO

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Employer(s)

Member

- A regular employee of the Employer working in the United States.
- Actively At Work at least 30 hours each week.
- A citizen or resident of the United States.

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

All Members

If you are a Member on the Group Policy Effective Date, you are eligible on that date.

If you become a Member after the Group Policy Effective Date, you are eligible on 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.

For you and your Dependents: Contributory

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

The cost of insurance may be funded by contributions to an IRC Section 125 Cafeteria Plan.

All benefits are based on a per day schedule. With respect to Emergency Benefits (Air Ambulance, Ground Ambulance, Emergency Room Benefit, and Urgent Care Benefit), a day is based on a 24 hour period. All other benefits are based on a calendar day.

Air Ambulance Benefit	\$500 per day
Ground Ambulance Benefit	\$300 per day
Emergency Room Benefit	\$100 per day
Urgent Care Benefit	\$50 per day

Hospitalization Benefits

Critical Care Unit Admission Benefit	\$500 per day
Daily Critical Care Unit Confinement Benefit	\$100 per day
Daily Hospital Confinement Benefit	\$200 per day
Hospital Admission Benefit	\$1,500 per day

Skilled Care Benefits

Daily Rehabilitation Facility Benefit	\$50 per day
Daily Skilled Nursing Facility Benefit	\$50 per day

Surgical Benefits

Inpatient Surgery Benefit	\$500 per day
Inpatient Surgical Anesthesia Benefit	25% per day of the Inpatient Surgery Benefit amount

Treatment Benefits

Follow Up Care Benefit	\$25 per day
Hearing Device Benefit	\$1,500 per day

Imaging and Lab Benefits

Major Diagnostic Exam Benefit	\$50 per day
Outpatient X- Ray and Lab Benefit	\$50 per day

Additional Benefits

Health Maintenance Screening Benefit	\$50 per day
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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 365 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 365 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, a foster or adopted Child, that Child is automatically insured for 31 days from the moment of birth or placement. If you are required to insure your child as a result of a court or administrative order, your Child is automatically insured for 31 days from the effective date of the court or administrative order, 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 or effective date of the court or administrative order 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.

Emergency Care Benefits

Air Ambulance Benefit

We will pay an Air Ambulance Benefit for the days you or your Dependent meet the following requirements:

- Transportation via air Ambulance was for the same Loss for which a Daily Hospital Confinement Benefit, Hospital Admission Benefit, or Emergency Room Benefit is payable.
- For an Injury, transportation was to or from a Hospital or between Health Service Facilities within 72 hours of the Injury.

We will pay an Air Ambulance Benefit for up to 1 day(s) per insured person per Calendar Year. An Air Ambulance and Ground Ambulance Benefit may be payable for the same Loss.

Emergency Room Benefit

We will pay an Emergency Room Benefit for the day(s) you or your Dependent meet the following requirements:

- Visit an Emergency Room due to a Sickness.
- For an Injury, visit an Emergency Room within 90 hours of the Injury.

We will pay an Emergency Room Benefit for up to 1 day(s) per insured person per Calendar Year.

Ground Ambulance Benefit

We will pay a Ground Ambulance Benefit for the day(s) you or your Dependent meet the following requirements:

- Transportation via ground Ambulance was for the same Loss for which a Daily Hospital Confinement Benefit, Hospital Admission Benefit, or Emergency Room Benefit is payable.
- For an Injury, transportation was to or from a Hospital or between Health Service Facilities within 90 days of the Injury.

We will pay a Ground Ambulance Benefit for up to 1 day(s) per insured person per Calendar Year. A Ground Ambulance Benefit and Air Ambulance Benefit may be payable for the same Loss.

Urgent Care Benefit

We will pay an Urgent Care Benefit for the day(s) you or your Dependent meet the following requirements:

- Visit an Urgent Care Facility due to a Sickness.
- For an Injury, visit an Urgent Care Facility within 72 hours of the Injury.

We will pay an Urgent Care Benefit for up to 4 day(s) per insured person per Calendar Year. An Urgent Care Benefit is not payable if an Emergency Room Benefit is payable for the same Loss.

Hospitalization Benefits

Critical Care Unit Admission Benefit

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

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

We will pay a Critical Care Unit Admission Benefit for the day of admission. We will pay a Critical Care Unit Admission Benefit for up to 1 day(s) per insured person per Calendar Year. A Critical Care Unit Admission Benefit is not payable if a Daily Rehabilitation Facility Benefit is payable for the same days for the same Loss.

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

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. A Daily Critical Care Unit Confinement Benefit is not payable if a Daily Rehabilitation Facility Benefit is payable for the same days for the same Loss.

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 90 days of the Injury.

We will pay a Daily Hospital Confinement Benefit for up to 30 days per Confinement per insured person. A Daily Hospital Confinement Benefit is not payable if a Daily Rehabilitation Facility Benefit is payable for the same day(s) for the same Loss.

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. A Hospital Admission Benefit is not payable if a Daily Rehabilitation Facility Benefit is payable for the same days of the same Loss.

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.

Skilled Care Benefits

Daily Rehabilitation Facility Benefit

We will pay a Daily Rehabilitation Facility Benefit for the days you or your Dependent meet all of the following requirements:

- Confined in a Rehabilitation Facility due to a Loss.
- Confinement in the Rehabilitation Facility immediately follows a Confinement in a Hospital for which a Daily Hospital Confinement Benefit was payable.

We will pay a Daily Rehabilitation Facility Benefit for up to 15 days per insured person per Calendar Year. We will not pay a Daily Rehabilitation Facility Benefit if a Daily Hospital Confinement Benefit, Daily Critical Care Unit Confinement Benefit is payable for the same day(s) for the same Loss.

If you or your Dependent become Confined to a Rehabilitation Facility 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 Rehabilitation Facility Benefit is payable at a time, even if Confinement is caused by more than one Loss.

Daily Skilled Nursing Facility Benefit

We will pay a Daily Skilled Nursing Facility Benefit for the days you or your Dependent meet all of the following requirements:

- Confined in a Skilled Nursing Facility due to a Loss.
- Confinement in the Skilled Nursing Facility immediately follows a Confinement in a Hospital for which a Daily Hospital Confinement Benefit was payable.

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

If you or your Dependent become Confined to a Skilled Nursing Facility 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 Skilled Nursing Facility Benefit is payable at a time, even if Confinement is caused by more than one Loss.

Surgical Benefits

Inpatient Surgery Benefit

We will pay an Inpatient Surgery Benefit for the days you or your Dependent meet the following requirements:

- A Physician performs a Surgical Procedure due to a Loss.
- Confined in a Hospital and a Daily Hospital Confinement Benefit is payable on the day the Surgical Procedure is performed.
- For an Injury, the Surgical Procedure is within 30 days of the Injury.

We will pay an Inpatient Surgery Benefit for up to 2 day(s) per insured person per Calendar Year. We will pay only for the day you or your Dependent undergo the Surgical Procedure, regardless of the number of days you or your Dependent remain Confined in the Hospital.

Inpatient Surgical Anesthesia Benefit

We will pay an Inpatient Surgical Anesthesia Benefit for the day(s) you or your Dependent meet all of the following requirements:

- Anesthesia is administered for a Surgical Procedure due to a Loss.
- An Inpatient Surgery Benefit is payable on the day the anesthesia is administered.

We will pay an Inpatient Surgical Anesthesia Benefit for up to 2 day(s) per insured person per Calendar Year.

Treatment Benefits

Follow Up Care Benefit

We will pay a Follow Up Care Benefit if you or your Dependent meet all of the following requirements:

- Visit a Health Care Provider for Follow Up Care due to a Loss.
- The Follow Up Care occurs within 90 days after Initial Care for the same Loss, with completion of the Follow Up Care within 365 days of the Initial Care.

We will pay a Follow Up Care Benefit for up to 4 day(s) per insured person per Calendar Year not to exceed a total of 12 day(s) per insured family per Calendar Year.

A Follow Up Care Benefit is not payable if Follow Up Care is rendered in an Urgent Care Facility or Emergency Room; and an Urgent Care Benefit or Emergency Room Benefit is payable for the same Loss.

Follow Up Care means a visit to a Health Care Provider for ongoing medical services due to a Loss. Follow Up Care does not include occupational therapy, speech therapy, physical therapy, or chiropractic treatment.

Initial Care means the first visit for Outpatient medical services. Initial Care does not include visits for wellness, annual physicals, acupuncture, preventive treatment, physical therapy, or for treatments for a chiropractic, allergy or immunotherapy, vision, speech, or hearing disorder.

Hearing Device Benefit

We will pay a Hearing Device Benefit if you or your Dependent meet the following requirements:

- Suffer a Moderate Loss Of Hearing due to a Loss and not due to the natural aging process.
- A licensed hearing aid specialist, audiologist, or a Diplomate of the American board of Otolaryngology recommends a Hearing Device.
- For an Injury, the recommendation of the Hearing Device is within 90 days of the Injury.
- A Hearing Device is procured within 365 days of the recommendation.

We will pay a Hearing Device Benefit once per insured person.

Hearing Device means an electronic device worn in or on the ear to help a person who has hearing loss to improve one's ability to hear.

Moderate Loss Of Hearing means a loss of between 56-70 dB as certified by a licensed hearing aid specialist, audiologist, or a Diplomate of the American board of Otolaryngology. Moderate Loss Of Hearing will result in difficulty hearing conversations, especially while in groups or with background noise.

Imaging and Lab Benefits

Major Diagnostic Exam Benefit

We will pay a Major Diagnostic Exam Benefit if you or your Dependent meet the following requirements:

- Undergo a Major Diagnostic Exam due to a Loss.
- For an Injury, the Major Diagnostic Exam is performed within 90 days of the Injury.

Major Diagnostic Exam means:

- Computerized Tomography (CT) scan.
- Magnetic Resonance Imaging (MRI).
- Electroencephalogram (EEG).
- Magnetic Resonance Angiogram scan (MRA).
- Positron Emission Tomography (PET).
- Spectroscopy (SPECT).

We will pay a Major Diagnostic Exam Benefit 4 day(s) per insured person per Calendar Year not to exceed a total of 12 day(s) per insured family per Calendar Year.

Outpatient X-Ray and Lab Benefit

We will pay an Outpatient X-Ray and Lab Benefit if you or your Dependent meet all of the following requirements:

- Undergo an X-ray or lab exam due to a Loss.
- An X-ray or lab exam is performed on an Outpatient basis within 90 days of the Loss.

We will pay an Outpatient X-ray and Lab Benefit for up to 1 day(s) per insured person per Calendar Year. The Outpatient X-Ray and Lab Benefit is not payable for a routine physical, or wellness exam, or if a Health Maintenance Screening Benefit is payable.

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 A1C.
- 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. War does not include being at the scene of an act of terrorism and not participating in that act.
- 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.
- Alcoholism, drug abuse, misuse of alcohol or any other substance, the voluntary use or consumption of any drug or alcohol in excess of the legal limit in the state in which the Injury occurred, or taking of drugs 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 180 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 180 day period.

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 immediately 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 recovery 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.

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.

Ambulance (Ground or Air)

A licensed professional ground or air ambulance company to transport you or your Dependent to or from a Hospital, or between Health Service Facilities 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 or foster child until age 26.
- Your stepchild, 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, Rehabilitation Facility or Skilled Nursing Facility 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 a change of Status as defined under your Employer's IRC Section 125 Cafeteria Plan. The change must be allowed by your Employer's IRC Section 125 Cafeteria Plan.

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 or admitted to Rehabilitation Facility, or Skilled Nursing Facility 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. A non-elective cesarean section is considered a complication 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.