

## **HOSPITAL INDEMNITY PLAN 8**



**METROPOLITAN LIFE INSURANCE COMPANY  
NEW YORK, NEW YORK**

**CERTIFICATE OF HOSPITAL INDEMNITY INSURANCE**

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. References to coverage for Your Dependents throughout this Certificate only apply if insurance is in effect for Your Dependents. Please refer to the Covered Persons Specifications page and Eligibility Provisions: Dependent Insurance section for details.

This Certificate is issued to You under the Group Policy. This Certificate includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.** The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

|                           |                                                |
|---------------------------|------------------------------------------------|
| Group Policyholder:       | The School Board of Miami-Dade County, Florida |
| Group Policy Number:      | 0024400                                        |
| MetLife Toll Free Number: | 1-800-GETMET8                                  |

**Important Notice:** The insurance evidenced by this Certificate provides limited benefits. The benefit amounts shown on the Schedule are not based on any medical expenses that are incurred. You should have medical coverage in force when You enroll for this insurance.

**This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with Your taxes.**

**30-Day Right to Examine Certificate.** Please read this Certificate carefully. If You are not satisfied for any reason, You may notify Us that You are cancelling Your Certificate within 30 days from the date of delivery by calling us at 1-800-GETMET8. If You notify Us that You are cancelling within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.

**Florida Residents: The benefits of the policy providing Your coverage are governed primarily by the laws of a state other than Florida.**

**Maryland Residents: The Group Policy providing coverage under this Certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.**

**WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.**

**IMPORTANT NOTICE**

For information about coverage or assistance in resolving complaints

contact Us at 1-800-GETMET8

## **NOTICE FOR RESIDENTS OF FLORIDA**

If You were a resident of Florida on Your Certificate effective date, this notice applies to You.

The following provision is added to the When Insurance Ends section of this Certificate if that section does not include an Extension of Benefits provision. If the When Insurance Ends section includes an Extension of Benefits provision, We will only pay benefits under one provision, which will be the one that pays the most.

### **EXTENSION OF BENEFITS**

If a Covered Person is Confined on the date Your insurance ends, and You do not continue insurance under the At Your Option: Continuation with Premium Payment provision, We will pay certain benefits for such Covered Person if the Confinement continues after Your insurance ends, in accordance with, and subject to all of the following:

- No benefits will be available under this Extension of Benefits provision if Your insurance ends due to non-payment of premium.
- The Confinement Benefit will be payable if requirements for payment of that benefit are met while the Covered Person is Confined. No other benefits will be payable.
- Benefits payable under this Extension of Benefits provision will be paid in accordance with and subject to the terms and conditions of this Certificate, except as set forth in this provision.
- Benefits under this Extension of Benefits provision will end on the earlier of:
  - the date the Covered Person is no longer Confined; or
  - the end of the number of days that Confinement Benefits are payable for the Confinement.
- If the Covered Person is again Confined at any time after discharge, no further benefits will be payable.

## **NOTICE FOR RESIDENTS OF MAINE**

If You were a resident of Maine on Your Certificate effective date, this notice applies to You.

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as non-payment of a Contribution that is due. You may make this designation by completing a "Third Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this Certificate to obtain a Third Party Notice Request Form.

Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the Certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

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## COVERED PERSON SPECIFICATIONS

|                                             |                                                                                                                                                                                                                                     |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Certificate Effective Date:                 | The later of January 1, 2027 or the Certificate Effective Date shown on the insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife |
| Group Policyholder:<br>Group Policy Number: | The School Board of Miami-Dade County, Florida<br>0024400                                                                                                                                                                           |
| MetLife Contact Information:                | 1-800-GETMET8                                                                                                                                                                                                                       |
| Your Name:                                  | See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife                                                                     |
| Your Certificate Number:                    | See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife                                                                     |
| Coverage for Your Dependents                | See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife                                                                     |

This Covered Person Specifications page is part of Your Certificate. Please keep it with Your Certificate.

## SCHEDULE OF INSURANCE

**IMPORTANT NOTE: Payment of the benefits listed in this Schedule is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate. PLEASE READ THE ENTIRE CERTIFICATE CAREFULLY.**

The benefits listed only apply to Dependents if insurance is in effect for Your Dependents under this Certificate. Please refer to the Covered Person Specifications page and the Eligibility Provisions: Dependent Insurance section of this Certificate for details.

### HOSPITAL BENEFITS

#### Benefit / Limit

##### Admission Benefit

\$50 for the day of admission

We will pay the Admission Benefit no more than: one time per Confinement; and 4 times per Covered Person, per calendar year

##### ICU Supplemental Admission Benefit

\$50 for the day of admission

##### Confinement Benefit

The Confinement Benefit is not payable for a day for which the Admission Benefit is payable.

\$50 per day

We will pay the Confinement Benefit for no more than:

30 days per Covered Person, per Confinement

##### Confinement Benefit for Newborn Nursery Care

\$50 per day

We will pay the Confinement Benefit for Newborn Nursery Care for no more than 3 days per newborn baby

##### ICU Supplemental Confinement Benefit

\$50 per day

We will pay the ICU Supplemental Confinement Benefit for no more than:

30 days per Covered Person, per Confinement

##### Inpatient Rehabilitation Benefit

\$50 per day

We will pay the Inpatient Rehabilitation Benefit for no more than:

30 days per Covered Person, per calendar year

## DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. Other terms may be defined where they are used. When defined terms are used in this Certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Accident** means an act or event which:

- is unforeseen, unexpected and unanticipated;
- is definite as to time and place;
- is not a Sickness; and
- occurs while insurance is in effect under this Certificate.

The term Accident includes unavoidable exposure to the elements if such exposure was a direct result of an Accident.

**Accidental** means happening by Accident.

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job on a Part-Time basis. This must be done at:

- the Group Policyholder's place of business;
- an alternate place approved by the Group Policyholder; or
- a place to which the Group Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Group Policyholder approved vacations, holidays or temporary business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Certificate** means this Certificate including any riders attached to it.

**Complications of Pregnancy** means diseases or conditions, the diagnoses of which are distinct from pregnancy and not associated with normal pregnancy or Routine Childbirth, but are adversely affected or caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; non-elective or emergency Caesarean section; ectopic pregnancy which is terminated; a spontaneous termination of pregnancy when a viable birth is not possible; puerperal infection; eclampsia; hyperemesis gravidarum and pre-eclampsia requiring Confinement; toxemia; missed abortion; or disease of the vascular, hemopoietic, nervous or endocrine systems.

The term Complications of Pregnancy does not include: false labor; occasional spotting; doctor prescribed rest during the period of pregnancy; morning sickness; multiple gestation pregnancy; elective abortion; or conditions of comparable severity associated with management of a difficult pregnancy.

**Confined or Confinement** means the assignment to a bed as a resident inpatient in a Hospital (including an Intensive Care Unit of a Hospital) on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

**Contribution** means the amount You must pay towards the total premium charged by Us for insurance under this Certificate.

**Covered Person** means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.

**Dependent** means Your Spouse, and/or Dependent Child. No person can be insured for Hospital Indemnity Insurance under the Group Policy as both an employee and a Dependent.

## DEFINITIONS (Continued)

**Dependent Child** means the following:

- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, while such child is younger than the Dependent Child Age Limit;
- Your stepchild, including a child of Your Domestic Partner, while such child is younger than the Dependent Child Age Limit; or
- A child for whom You or Your Spouse are appointed legal guardian, or a child placed with You or Your Spouse as a foster child, while such child is under the Dependent Child Age Limit, and subject to the legal guardianship or continuing foster parent status of You or Your Spouse.

The term Dependent Child does not mean an unborn or stillborn child.

A person cannot be insured for Hospital Indemnity Insurance as a Dependent Child of more than one employee under the Group Policy.

**Dependent Child Age Limit** means:

- the end of the calendar year in which the Dependent Child reaches age 26; or
- the end of the calendar year in which the Dependent Child reaches age 30 if the Dependent Child is a resident of Florida or a student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

**Dependent Insurance** means insurance under this Certificate for Your Dependents.

**Domestic Partner** means each of two people, one of whom is You, who:

1. have registered as each other's domestic partner or civil union partner with a government agency where such registration is available; or
2. are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  - 18 years of age or older;
  - unmarried;
  - the sole domestic partner of the other;
  - sharing a Primary Residence with the other; and
  - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by You.

## DEFINITIONS (Continued)

**Emergency Room** means an area within a Hospital that is dedicated to the provision of emergency care. This area must:

- be staffed and equipped to handle trauma;
- be supervised and provide treatment by Physicians; and
- provide care seven days per week, 24 hours per day.

The term Emergency Room includes short stay observation units or clinical decision units within a Hospital that assess, within a period of less than 20 continuous hours, whether to discharge or admit patients.

**Group Policy** means the policy of insurance issued by Us to the Group Policyholder under which this Certificate is issued.

**Group Policyholder** means The School Board of Miami-Dade County, Florida.

**Hospice Facility** means a facility, unit of a facility, public or private agency, or unit of a public or private agency that:

- is separate from a Hospital or is a separately designated unit within a Hospital; and
- meets federal certification requirements as a hospice, or is comparably licensed under the laws where it is located, to provide care or management of persons who are diagnosed with a Terminal Illness.

**Hospital** means a short-term, acute care, general facility which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts or alcoholics, or a place for convalescent, custodial, or educational care.

The term Hospital does not include a separate unit of a Hospital that is licensed as a hospice facility, nursing home, skilled nursing facility, assisted living facility, rehabilitation facility or an outpatient Surgery facility.

**Injury** means any bodily harm that results directly from an Accident.

## DEFINITIONS (Continued)

**Intensive Care Unit or ICU** means a place which:

- is a specifically dedicated area of a Hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive monitoring and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under close observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and
- has a Physician assigned to the intensive care unit on a full-time basis.

The term Intensive Care Unit includes Hospital units with the following names: intensive care unit; coronary care unit; neonatal intensive care unit; pulmonary care unit; burn unit; or transplant unit.

**Medical Restriction** means a person is:

- restricted to the person's home under a Physician's care;
- receiving or applying to receive disability benefits from any source;
- an inpatient in a Hospital;
- receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receiving chemotherapy, radiation therapy or dialysis.

**Newborn Nursery Care** means routine well baby care provided to a newborn baby while Confined immediately following a Covered Person's childbirth of such baby.

**Nurse** means a registered professional nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) who is licensed under the laws where the services are performed.

The term Nurse does not include:

- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone with whom You are residing;
- Your adopted or stepchild;
- anyone with whom You share a business interest; or
- Your employee.

**Part-Time** means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 5 hours per week.

## DEFINITIONS (Continued)

**Physician** means:

- a person licensed to practice medicine and prescribe and administer drugs or to perform Surgery in the jurisdiction where such services are performed; or
- a medical practitioner who is licensed to provide a service for which a benefit is payable under this Certificate, according to the laws and regulations of the jurisdiction where such service is performed, and who is acting within the scope of such license.

The term Physician does not include:

- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone with whom You are residing;
- Your adopted or stepchild;
- anyone with whom You share a business interest; or
- Your employee.

**Primary Residence** means the dwelling where a person lives for the majority of the time, whether the person owns or rents the dwelling.

**Proof** means Written evidence satisfactory to Us that a claimant has satisfied the conditions and requirements for any benefit described in this Certificate. When a claim is made for any benefit described in this Certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Except as provided in the Examinations and Autopsy provisions of this Certificate, Proof must be provided at the claimant's expense.

**Rehabilitation Facility** means a facility that:

- provides rehabilitation care services on an inpatient basis;
- is separate from a Hospital or is a separately designated unit within a Hospital; and
- maintains all required licenses and certifications.

Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by an Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians.

The term Rehabilitation Facility does not include:

- a nursing home;
- an extended care facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the extended care facility;
- a Skilled Nursing Facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the facility;
- a rest home or home for the aged;
- a Hospice Facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

**Routine Childbirth** means the vaginal delivery of a child or children or the delivery of a child or children by elective Cesarean section.

**Routine Pregnancy** means a normal pregnancy that does not have Complications of Pregnancy.

## DEFINITIONS (Continued)

**Schedule** means the Schedule of Benefits that appears in this Certificate, and the Covered Person Specifications page.

**Sickness** means:

- a physical illness, physical infirmity or physical disease;
- Complications of Pregnancy; or
- Routine Childbirth.

The term Sickness does not include Routine Pregnancy.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record. The signature may be transmitted by paper or electronic media, provided it is consistent with applicable law.

**Skilled Nursing Facility** means a facility that provides nursing care that meets all of the following requirements:

- if licensing or certification is required, maintains all appropriate licensing or certification under the laws where it is located as a skilled or intermediate nursing facility;
- has 24 hour a day care performed by an awake, and trained or certified staff supervised by a Nurse;
- is separate from a Hospital or is a separately designated unit within a Hospital;
- keeps a Written record of services performed for each client;
- has established procedures to obtain emergency medical care; and
- services are not limited to provision of food, shelter, and other residential services such as laundry.

The term Skilled Nursing Facility does not include a Hospice Facility.

**Spouse** means Your lawful spouse or Your Domestic Partner.

**Surgery** means a procedure performed by a Physician involving an incision of the Covered Person's skin or tissue that, in and of itself, is intended to be curative, palliative or exploratory.

**United States** means the United States of America, its territories and its possessions.

**We, Us and Our** mean Metropolitan Life Insurance Company.

**Write, Written or Writing** means a record that may be transmitted by paper or electronic media, and that is consistent with applicable law.

**You and Your** means an employee who is insured under the Group Policy for the insurance described in this Certificate.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS**

#### **CLASS 4**

All Active Part-Time Employees

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

You may only become eligible for the Hospital Indemnity Insurance available for Your eligible class.

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

If you enter an eligible class after the date insurance becomes available to members of that class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

### **ENROLLMENT PROCESS**

If You are eligible for insurance, You may enroll for such insurance by completing the required form. You must also provide Written permission to deduct Contributions from Your pay for such insurance, if You are required to make such Contributions.

### **DATE YOUR INSURANCE TAKES EFFECT**

Provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Certificate effective date. If You are not Actively at Work in an eligible class on the date insurance would otherwise take effect, insurance will take effect on the date You return to Active Work in an eligible class.

### **BENEFIT CHANGES**

Once Your insurance takes effect, You may only change Your benefits in accordance with the options available through the Group Policyholder. Please contact Us or the Group Policyholder for more information.

If You are not Actively at Work in an eligible class on the date an increase in benefits would otherwise take effect, the increase will not take effect until You return to Active Work in a class that is eligible for the increase.

## **ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE**

### **ELIGIBLE CLASS FOR DEPENDENT INSURANCE**

All Class 4 employees of the Group Policyholder as specified in the Eligibility Provisions: Insurance For You section of this Certificate are eligible for Dependent Insurance.

### **DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE**

If You are in a class of employees who are eligible for Dependent Insurance on the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date Your insurance takes effect; and
- the date an individual becomes Your first Dependent.

If You enter a class of employees who are eligible for Dependent Insurance after the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date You enter a class eligible for Dependent Insurance; and
- the date an individual becomes Your first Dependent.

### **ENROLLMENT PROCESS**

If You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with any information We require for each Dependent to be insured. You must also provide Written permission to deduct Contributions from Your pay for Dependent Insurance, if You are required to make such Contributions.

### **DATE DEPENDENT INSURANCE TAKES EFFECT**

#### **Newborn Children**

A Dependent Child born to You while insurance is in effect under the Certificate will be covered:

- from the moment of birth and does not need to be enrolled if Dependent Insurance is already in effect for at least one other Dependent Child; or
- for 31 days from the moment of birth if Dependent Insurance is not already in effect for at least one other Dependent Child. To continue coverage beyond the first 31 days You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child.

The effective date of insurance for a newborn child will be determined without regard to whether the child is under a Medical Restriction.

## **ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (Continued)**

### **Adopted Children**

A Dependent Child adopted by You or Placed for Adoption with You while insurance is in effect under the Certificate will be covered:

- from the moment of birth if a written agreement to adopt the child has been executed by You prior to the child's birth; or
- from the date of adoption or Placement for Adoption if a written agreement to adopt the child was not executed by You prior to the child's birth.

Coverage will continue unless the child's placement is disrupted prior to legal adoption.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of the child's adoption or Placement for Adoption and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the adopted child. You must do this within 60 days of the date the child is adopted by You or Placed for Adoption with You.

The effective date of insurance for a newly adopted child will be determined without regard to whether the child is under a Medical Restriction.

**Placed for Adoption** or **Placement for Adoption** means the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child.

### **Other Dependents**

Dependent Insurance for a Dependent who is not under a Medical Restriction will take effect on the later of:

- the date You are enrolled for Dependent Insurance for such Dependent; or
- the date a person becomes Your Dependent.

If a Dependent is under a Medical Restriction on the date insurance for such Dependent would otherwise take effect, insurance for the Dependent will take effect on the date the Dependent is no longer under a Medical Restriction.

## **BENEFIT CHANGES**

Benefit changes with respect to a Dependent are subject to the Benefit Changes provision in the Eligibility Provisions: Insurance for You section of this Certificate.

## **HOSPITAL BENEFITS**

**Payment of the Hospital Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.**

### **HOSPITAL ADMISSION BENEFITS**

#### **Admission Benefit**

If a Covered Person is admitted for Confinement to a Hospital for treatment of an Injury or Sickness, We will pay the Admission Benefit shown on the Schedule for the day of admission, subject to all of the following:

- The admission must occur on or after the date that coverage took effect under this Certificate for such Covered Person.
- The Admission Benefit is not payable for Emergency Room treatment or outpatient treatment.
- We will only pay the Admission Benefit for a Covered Person for one Hospital admission at a time, even if the admission is caused by more than one Injury or Sickness or a combination of Injury and Sickness.
- For Hospital admission for treatment of an Injury, the admission must occur within 180 days after the Accident occurs.
- If a Covered Person is discharged from a Confinement for which We paid an Admission Benefit and, within 90 days is again Confined for the same or related Injury or Sickness, We will treat the subsequent Confinement as a continuation of the previous Confinement (and an additional Admission Benefit will not be payable).
- We will only pay an Admission Benefit for a newborn baby who is born in a Hospital if, due to a Sickness or Injury, the newborn baby is admitted to the Intensive Care Unit.
- If a Covered Person is admitted to a Hospital and is then transferred to another Hospital, We will not pay an additional Admission Benefit.
- We will pay the Admission Benefit no more than the number of times shown on the Schedule.

#### **ICU Supplemental Admission Benefit**

We will pay the ICU Supplemental Admission Benefit shown on the Schedule, in addition to the Admission Benefit, if a Covered Person, upon initial admission for Confinement to a Hospital for treatment of an Injury or Sickness, is admitted to an ICU, subject to all of the following:

- The admission must meet the requirements for payment of the Admission Benefit.
- For an ICU admission for treatment of an Injury, the admission must occur within 180 days after the Accident occurs.
- If the Covered Person moves to an ICU after initial admission to a Hospital, We will not pay the ICU Supplemental Admission Benefit.

## **HOSPITAL BENEFITS (Continued)**

### **HOSPITAL CONFINEMENT BENEFITS**

#### **Confinement Benefit**

If a Covered Person is Confined in a Hospital for treatment of an Injury or Sickness, We will pay the Confinement Benefit shown on the Schedule for each day of Confinement, subject to all of the following:

- The Confinement must begin while coverage is in effect under this Certificate for such Covered Person. For Confinement for treatment of an Injury, the Confinement must begin within 180 days after the Accident occurs.
- If the Covered Person is discharged from the Hospital and, within 90 days is again Confined for the same or related Injury or Sickness, We will treat the subsequent Confinement as a continuation of the previous Confinement.
- If a Covered Person is Confined in a Hospital and is then transferred to another Hospital, We will treat the transfer as a continuation of the prior Confinement.
- We will only pay one Confinement Benefit per Covered Person, per day.
- We will not pay a Confinement Benefit for a day that the Admission Benefit is payable.
- We will pay the Confinement Benefit for no more than the number of days shown on the Schedule.
- For a newborn baby who is receiving Newborn Nursery Care and is not Confined for treatment of a physical illness, infirmity, disease or Injury, We will pay the Confinement Benefit for Newborn Nursery Care shown on the Schedule for such baby, while Confined, up to the number of days shown on the Schedule. If a newborn baby is Confined for treatment of a physical illness, infirmity, disease or Injury, We will pay the Confinement Benefit instead of the Confinement Benefit for Newborn Nursery Care.

#### **ICU Supplemental Confinement Benefit**

We will pay the ICU Supplemental Confinement Benefit shown on the Schedule, in addition to the Confinement Benefit, for each day a Covered Person is Confined in an ICU for treatment of an Injury or Sickness, subject to all of the following:

- The ICU Confinement must meet the requirements for payment of the Confinement Benefit.
- We will only pay the ICU Supplemental Confinement Benefit for a day on which the Confinement Benefit is payable.
- For an ICU Confinement for treatment of an Injury, Confinement in the Intensive Care Unit must begin within 180 days after the Accident occurs.
- We will pay the ICU Supplemental Confinement Benefit for no more than the number of days shown on the Schedule.

### **INPATIENT REHABILITATION BENEFIT**

If a Covered Person is transferred to a Rehabilitation Facility, as a resident inpatient, immediately after a period of Confinement for treatment of an Injury for which We paid an Admission Benefit or Confinement Benefit, We will pay the Inpatient Rehabilitation Benefit shown on the Schedule for the period of the continuous stay, subject to all of the following:

- The Covered Person's inpatient stay in the Rehabilitation Facility must start within 365 days after the Accident occurs.
- If the Covered Person is discharged from the Rehabilitation Facility and, within 14 days is again admitted to a Rehabilitation Facility as a resident inpatient for treatment of the same or related Injury, We will treat the subsequent Rehabilitation Facility stay as a continuation of the previous stay.
- We will not pay the Inpatient Rehabilitation Benefit for any day for which We paid an Admission Benefit or a Confinement Benefit.
- We will only pay one Inpatient Rehabilitation Benefit per Covered Person, per day.
- We will pay the Inpatient Rehabilitation Benefit for no more than the number of days shown on the Schedule.

## OTHER BENEFITS

Payment of the Other Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

### WAIVER OF PREMIUM

**Disabled** or **Disability** means that, solely due to an Injury or Sickness for which We paid a benefit under this Certificate, You are:

- prevented from performing any occupation for which You are or become reasonably fitted by Your education, training or experience;
- not gainfully employed; and
- receiving appropriate care and treatment from a Physician who is appropriate to treat the Sickness or Injury; however, We may waive this requirement if Your Physician provides documentation acceptable to Us that continued care would be of no benefit to You.

If You become Disabled while You are under age 70 and insured under this Certificate, and You remain Disabled continuously for 180 days, We will waive the premiums due for You and Your Dependents starting with the first premium that becomes due on or after the date You have been Disabled continuously for 180 days, subject to all of the following:

- After You have been disabled continuously for 180 days, Proof of the Disability must be sent to Us within the next 90 days or You will not be eligible for Waiver of Premium.
- When We receive such Proof, We will review the claim. Premiums will not be waived unless We approve the claim.
- We may choose a Physician to examine You to verify that You are Disabled. If We do so, We will pay for such exam.

We will not waive premiums under this provision if:

- You do not remain insured under this Certificate during the first 180 days of continuous Disability; or
- Your Disability is not solely caused by an Injury or Sickness for which We have paid a benefit under this Certificate.

**OTHER BENEFITS (Continued)**

If We waive any premium under this provision that has already been paid to Us, We will return the premium to whomever paid it to Us.

To verify that You continue to be Disabled without interruption after Our initial approval, We may periodically ask You to send Us Proof that You continue to be Disabled.

We will continue to waive premiums under this provision until the earliest of:

- the date You are no longer Disabled;
- the date You fail to send us Proof that You continue to be Disabled as required under this provision;
- 1 year from the date We first began to waive premiums; or
- the date Your insurance under this Certificate ends.

**Important Notice**

On the date Your insurance ends, We may not know whether You will be able to satisfy the requirements for Waiver of Premium specified in this provision. If You do not continue Your insurance You will not be eligible for Waiver of Premium because You will not have been continuously insured during the first 180 days of Disability. For this reason, We urge You to read the section titled Continuation of Insurance and consider continuing Your insurance if You are able to do so.

## EXCLUSIONS

We will not pay benefits for any loss due to an Accident or Sickness for a Covered Person caused or contributed to by:

- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion, riot, or terrorist act;
- the Covered Person's engagement in any activity that constitutes a felony under the laws of the jurisdiction in which the activity occurred;
- dental procedures or Surgery except as the result of an Accident causing Injury to a sound natural tooth;
- cosmetic Surgery, except when such Surgery is performed to:
  - treat an Injury or Sickness;
  - correct a disorder of normal bodily function or structure that was caused by an Injury or Sickness for which coverage is not otherwise excluded under this Certificate; or
  - reconstruct a part of the body which was disfigured or removed as a result of an Injury or Sickness for which coverage is not otherwise excluded under this Certificate; or
- activities required by the Covered Person to carry out the duties and responsibilities of their service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, We will not pay benefits for a Covered Person while incarcerated in any type of penal or detention facility.

The following additional exclusions apply to payment of benefits for any loss due to an Accident:

We will not pay benefits for any loss due to an Accident for a Covered Person caused or contributed to by:

- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
  - intoxicated means that the Covered Person's blood alcohol level met or exceeded .08%; and
  - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all-terrain vehicle; or a snow mobile;
- the Covered Person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- the Covered Person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- the Covered Person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- the Covered Person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; or
- the Covered Person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

## WHEN INSURANCE ENDS

**Please Note:** If insurance ends under this section, in certain cases it may be continued as stated in the Continuation of Insurance section of this Certificate. Please see that section for details.

### DATE YOUR INSURANCE ENDS

Your insurance under this Certificate will end on the earliest of:

- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the end of the period for which the last full premium has been paid for Your insurance;
- the end of the calendar month in which You notify Us that You wish to cancel Your insurance;
- the end of the calendar month in which You cease to be in an eligible class, subject to the Change in Class provision of the Eligibility Provisions: Insurance for You section; or
- the end of the calendar month in which Your employment ends.

Please refer to the provision entitled Waiver of Premium for information concerning continuation of Your insurance if Your insurance ends while You are Disabled.

### For residents of Massachusetts:

If You are a resident of Massachusetts and Your insurance under this Certificate is ending under the above provision because Your employment has ended, instead of insurance ending on the date Your employment ends, the following timelines apply:

- If Your employment ends for any reason other than a Plant Closing or a Partial Plant Closing, Your insurance will end 31 days after the date Your employment ends. However, if during such 31 day period You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate, insurance under this Certificate will end on the date You become entitled to such other benefits.
- If Your employment ends due to a Plant Closing or a Partial Plant Closing Your insurance will end 90 days after the date Your employment ends. However, if during such 90 day period, You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate insurance under this Certificate will end on the date You become entitled to such other benefits.

### DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance under this Certificate will end on the earliest of:

- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the end of the calendar month in which the person ceases to be a Dependent;
- the end of the calendar month in which You cease to be in a class that is eligible for Dependent Insurance;
- the end of the calendar month in which the Dependent is no longer eligible as described in the Eligible Classes for Dependent Insurance provision; or
- the end of the period for which the last full premium has been paid for insurance for the Dependent.

## **WHEN INSURANCE ENDS (Continued)**

### **EXTENSION OF BENEFITS**

If a Covered Person is Confined on the date Your insurance ends, and You do not continue insurance under the At Your Option: Continuation with Premium Payment provision, We will pay certain benefits for such Covered Person if the Confinement continues after Your insurance ends, in accordance with, and subject to all of the following:

- No benefits will be available under this Extension of Benefits provision if Your insurance ends due to non-payment of premium.
- The Confinement Benefit will be payable if requirements for payment of those benefits are met while the Covered Person is Confined. No other benefits will be payable.
- Benefits payable under this Extension of Benefits provision will be paid in accordance with and subject to the terms and conditions of this Certificate, except as set forth in this provision.
- Benefits under this Extension of Benefits provision will end on the earlier of:
  - the date the Covered Person is no longer Confined; or
  - the end of the number of days that Confinement Benefits are payable for the Confinement.
- If the Covered Person is again Confined at any time after discharge, no further benefits will be payable.

### **CHANGE IN CLASS**

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:

- You move to a class that is eligible for Hospital Indemnity Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer a member of the class eligible for insurance under this Certificate.

## **CONTINUATION OF INSURANCE**

### **AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT**

If Your insurance ends under the Date Your Insurance Ends provision of this Certificate, in certain situations, it may be continued for You and Your Dependents, as described in this provision. This is referred to in this provision as "Continued Insurance". For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as "Group Billed Insurance".

Except as described below, Continued Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

#### **Requirements for Continued Insurance**

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
  - non-payment of premium or Contribution; or
  - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for hospital indemnity insurance under another policy of group insurance available through the Group Policyholder;
- We receive Your completed Written request for Continued Insurance on a form approved by Us within 31 calendar days after Your Group Billed Insurance ends; and
- You pay premiums required for Continued Insurance by the due date specified in the premium notice sent to You.

#### **Changes in Continued Insurance**

You may elect to decrease Your insurance after the date that Continued Insurance goes into effect for You if a lower benefit option is available. In addition, You may end insurance for any or all of Your Dependents. Please contact Us for information. You may not increase insurance once Continued Insurance goes into effect.

#### **Contributions for Continued Insurance**

The Contribution that You must pay for Continued Insurance is the amount of Your Contribution for Your Group Billed Insurance before it ended, plus any amount of premium that the Group Policyholder paid. The Contribution that You must pay for Continued Insurance will be determined on the same basis as premium rates charged for Group Billed Insurance. We have the right to change premium rates in accordance with the terms set forth in the Group Policy. All payments for Continued Insurance must be made directly to Us by the due date specified in the premium notice We send to You.

## **CONTINUATION OF INSURANCE (Continued)**

### **End of Continued Insurance**

Continued Insurance will end on the earliest of the following dates:

- the date You die;
- if You do not pay a Contribution that is required for Continued Insurance, the end of the period for which the last full premium has been paid for Your insurance;
- with respect to Continued Insurance for a Dependent:
  - the date Continued Insurance for You ends for any reason;
  - the end of the calendar month in which the Dependent no longer meets the definition of a Dependent; or
  - the end of the calendar month in which the Dependent is no longer eligible as described in the Eligibility Provisions: Dependent Insurance section of this Certificate.

### **FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN**

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date, but no more often than annually after the two year period following such Dependent Child's attainment of the limiting age.

Except as stated in the Date Dependent Insurance Ends provision of the When Insurance Ends section of this Certificate, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Dependent Child, except for the age limit.

### **FOR FAMILY AND MEDICAL LEAVE**

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) or similar state laws for continuation of insurance. Please contact the Group Policyholder for information regarding the FMLA or any similar state law.

## **CLAIMS**

### **NOTICE OF CLAIM**

You must give Us notice of a claim under this Certificate by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the loss.

### **CLAIM FORM**

When We receive notice of a claim under this Certificate, We will provide You or the claimant with a claim form. If We do not provide the claim form within 15 days from the date We received notice of claim, Our claim form requirements will be satisfied if We are provided with the required Proof in support of the claim.

### **PROOF OF LOSS**

Proof must be provided to Us not later than 90 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 12 months from the date of the loss.

### **PAYMENT OF BENEFITS**

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this Certificate and the Group Policy.

Unless You have assigned this insurance, all benefits to be paid under this Certificate will be paid to You, except as follows:

- If You are not alive to receive benefits that are payable to You, We will pay any benefits in accordance with the provision below titled Your Beneficiary.
- If You are living when benefits are to be paid to You, but You are not legally competent to claim or receive the benefits, We may pay up to \$10,000 to anyone related to You by blood or marriage who We believe is entitled to payment of the benefits. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If benefits have been assigned, We will pay benefits in accordance with the Assignment provision of the General Provisions section.

### **YOUR BENEFICIARY**

A beneficiary may be named by You to receive any benefit that becomes payable to You under this Certificate that You are not alive to receive.

You may request to change Your beneficiary at any time. A beneficiary change request must be made to Us in Writing. Once the request is recorded, the change will take effect as of the date You sign the request, whether or not You are living when We receive the request. The change will be subject to any legal restrictions. It will also be subject to any payment We made or action We took before We recorded the change. If You designated two or more beneficiaries and their shares are not specified, they will share the benefit payable equally.

If there is no beneficiary designated or no surviving beneficiary at Your death, We will determine the beneficiary according to the following order:

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

## **CLAIMS (Continued)**

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment. If a beneficiary or a Payee is a minor or incompetent to receive payment, We will pay that person's guardian.

## **AUTHORIZATIONS**

We may require that You provide authorization for Us to obtain medical information and any other information pertinent to Your claim.

## **EXAMINATIONS**

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may require a Covered Person to have an independent examination by a Physician of Our choice.

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

## **AUTOPSY**

At Our expense, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

## **TIME LIMIT ON LEGAL ACTIONS**

No legal action may be brought to recover on a claim within 60 days after the date Proof has been given as required by this Certificate. No such action may be brought after the expiration of the applicable statute of limitations from the date Proof is required to be given under the terms of this Certificate.

## **REFUND TO US FOR OVERPAYMENT OF BENEFITS**

If, at any time, We determine that the benefits paid under this Certificate were more than the benefits due:

- You, or any other person, entity or health care provider to whom We over paid benefits have the obligation to reimburse Us for the amount of such overpayment; and
- We have the right to recover the amount of such overpayment from You, or any other person, entity or health care provider to whom We over paid benefits, including offsetting future benefits payable to You or such other person, entity or health care provider by an amount equivalent to the overpayment.

## **GENERAL PROVISIONS**

### **ENTIRE CONTRACT**

Your insurance is provided under a contract of group insurance with the Group Policyholder. The entire contract with the Group Policyholder is made up of the following:

- the Group Policy and its Exhibits, which include the Certificate(s);
- the Group Policyholder's application; and
- any amendments and/or endorsements to the Group Policy.

### **INCONTESTABILITY: STATEMENTS MADE BY YOU**

Any statement made by You will be considered a representation and not a warranty. We will not use such a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in a form that is in Writing;
- You have Signed the form; and
- a copy of the form has been given to You or Your beneficiary.

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest a benefit increase after the benefit increase has been in force for 2 years, unless such statement is fraudulent.

### **MISSTATEMENTS**

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or Contributions.

### **ASSIGNMENT**

The benefits under the Group Policy are not assignable prior to a claim, except as required by law.

### **CONFORMITY WITH LAW**

If the terms and provision of this Certificate do not conform to any applicable law, this Certificate shall be interpreted to so conform.

### **STANDARD OF TIME**

All insurance becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Savings Time is then being observed.