

**Group Hospital Indemnity
Insurance Certificate**

University of Richmond

IMPORTANT NOTICES

GROUP HOSPITAL INDEMNITY

If you reside in one of the following states, please read the important notice applicable to you.

Arizona residents:

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

California residents:

THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW.

REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON THE EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

Colorado residents:

THIS IS A SUPPLEMENTAL POLICY THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

Florida residents:

The benefits of the policy providing your coverage are governed primarily by the laws of a state other than Florida.

To make an inquiry, obtain information about your coverage or to resolve a complaint call 1-800-547-5515.

Idaho residents:

30 Day Right To Examine Policy

If a Covered Person does not like the Policy for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Policy will be void as if it had never been issued.

THIS COVERAGE IS NOT GUARANTEED RENEWABLE

Maine residents:

**RENEWAL SUBJECT TO CONSENT OF COMPANY: PLEASE READ
TERMINATION OF POLICY PROVISION IN THE GENERAL PROVISIONS SECTION.**

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Maryland residents:

This Certificate may omit some of the benefits required for a Certificate issued and delivered in Maryland.

New Mexico residents:

THIS TYPE OF PLAN IS NOT CONSIDERED “MINIMUM ESSENTIAL COVERAGE” UNDER THE AFFORDABLE CARE ACT (ACA) AND THEREFORE DOES NOT SATISFY THE INDIVIDUAL MANDATE THAT YOU HAVE HEALTH INSURANCE COVERAGE. IF YOU DO NOT HAVE OTHER HEALTH INSURANCE COVERAGE, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. PLEASE CONSULT YOUR TAX ADVISOR.

New Hampshire residents:

THIS IS A LIMITED POLICY. READ IT CAREFULLY.

THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS POLICY IS RENEWABLE AT THE OPTION OF THE POLICYHOLDER AND/OR US

30 Day Right To Examine Certificate

If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

North Carolina residents:

This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but it is issued under a group master policy located in another state and may be governed by that state’s law.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from Us.

POLICY

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.

Ohio residents:

THIS POLICY 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.

Oklahoma residents:

NOTICE: The Policyholder has the right to return the Policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the Policy, the Policyholder is not satisfied for any reason. If We do not return any premiums or money paid therefore within thirty (30) days from the date of cancellation, We will pay interest on the proceeds.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony

South Dakota residents:

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE FOR COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS.

Utah residents:

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM THE COMPANY. WITHIN 30 DAYS OF RECEIPT OF THIS POLICY, YOU CAN RETURN IT TO US FOR ANY REASON IF NOT SATISFIED. WE WILL RETURN ANY PREMIUM THAT HAS BEEN PAID AND THE POLICY VOID.

Virginia residents:

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

IMPORTANT NOTICE REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have any questions you may contact Us at the address above or by calling toll-free 1-800-732-1603.

If you are unable to contact or obtain satisfaction from the company or agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at the following address and telephone numbers:

P.O. Box 1157

Richmond Virginia 23218-1157

(804) 371-9741 (local)

(800) 552-7945 (VA toll-free)

(877) 310-6560 (national toll-free)

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or Bureau of Insurance, have your policy number available.

West Virginia residents:

THIS POLICY DOES NOT QUALIFY FOR MINIMUM ESSENTIAL COVERAGE

TEN DAY RIGHT TO EXAMINE POLICY

The Policyholder has the right to return this Policy to Us within 10 days of receipt, and to have the premium refunded if, after examination, the Policyholder is not satisfied with this Policy for any reason.

Life Insurance Company of North America
1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235
A Stock Insurance Company

GROUP HOSPITAL INDEMNITY CERTIFICATE

**THIS CERTIFICATE PROVIDES LIMITED COVERAGE.
PLEASE READ YOUR CERTIFICATE CAREFULLY.**

**THIS IS A GROUP HOSPITAL INDEMNITY INSURANCE POLICY. BENEFITS PROVIDED ARE NOT
INTENDED TO COVER ALL MEDICAL EXPENSES.**

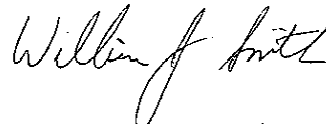
**THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE. THIS COVERAGE DOES
NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA).**

We, the Life Insurance Company of North America, have issued a Group Policy, HC960598 to Trustee of the Group Insurance Trust for Employers in the Services Industry.

We certify that We insure all eligible persons who are enrolled according to the terms of the Group Policy. Your coverage will begin according to the terms set forth in the *Effective Date Provisions* section.

This Certificate describes the benefits and basic provisions of Your coverage. It is not the insurance contract and does not waive or alter any terms of the Policy. If questions arise, the Policy language will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This Certificate replaces all prior Certificates issued to You under the Group Policy.



William J. Smith, President

30 DAY RIGHT TO EXAMINE CERTIFICATE

Within 30 days of receipt of this Certificate, You can return it to Us for any reason if not satisfied with the insurance provided under this Certificate. We will return any premium that has been paid and this Certificate will be void as if it had never been issued.

Series 1.1

GHIP-00-CE1000.00

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SCHEDULE OF BENEFITS

The *Schedule of Benefits* provides a brief outline of the coverage and benefits including the maximum benefit amount, benefit periods, and any limitations applicable to benefits provided in this Policy for each Covered Person, unless otherwise indicated.

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Policy provisions carefully.

Covered Classes:

Class 2 All active, Full-time Employees of the Employer regularly working a minimum of 1,511 hours annually, who are lawfully working and residing in the United States under an appropriate visa or work authorization and their Spouse and Dependent Children who are residing in the United States, except non-United States citizens from OFAC sanctioned countries.

The following pages contain a Schedule of Benefits for each class of eligible Employees. For an explanation of these benefits, please see the *Description of Benefits* section.

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SCHEDULE OF BENEFITS FOR CLASS 2

Subscriber: University of Richmond

Effective Date of Subscriber: January 01, 2020

Minimum Subscriber Participation Requirements:

None

Eligibility Waiting Period:

No Waiting Period

Benefit Waiting Period: 0 days unless otherwise specified

BENEFIT AMOUNTS PAYABLE

All Employee benefits are payable at 100% of the Benefit Amount shown for the Eligible Employee.

All Spouse benefits are payable at 100% of the Benefit Amount shown for the Employee, unless otherwise indicated.

All Dependent Child(ren) benefits are payable at 100% of the Benefit Amount shown for the Employee, unless otherwise indicated.

HOSPITAL INDEMNITY BENEFITS

PLAN 1

EMPLOYEE BENEFITS

HOSPITALIZATION BENEFITS

Benefit Type

Hospital Admission

Elimination Period	0 days
Benefit Amount	\$1,000 per day
Maximum Benefit Period	1 day

Hospital Chronic Condition Admission

Elimination Period	0 days
Benefit Amount	\$50 per day
Maximum Benefit Period	1 day

Hospital Stay

Elimination Period	0 days
Benefit Amount	\$100 per day
Maximum Benefit Period	Up to 30 days

Hospital Intensive Care Unit Stay

Elimination Period	0 days
Benefit Amount	\$200 per day
Maximum Benefit Period	Up to 30 days

Hospital Observation Stay

Elimination Period	24 hours
Benefit Amount	\$100 per 24-hour period
Maximum Benefit Period	Up to 72 hours

CONTINUATION OPTION(S):

Applicable Coverage(s)	Hospital Indemnity Benefits for the Employee, His Spouse and Dependent Child(ren)
For Family Medical Leave Maximum Benefit Period	up to 6 months
For Leave of Absence Maximum Benefit Period	up to 12 months
For Sabbatical Leave of Absence Maximum Benefit Period	up to 24 months
For Leave due to Disability Maximum Benefit Period	up to 26 weeks

PREMIUM INFORMATION

INITIAL PREMIUM

Premium:	Refer to your Schedule of Rates or Plan and Rate Confirmation as provided at time of enrollment or application
Contribution(s):	The cost of coverage is paid by the Employee

PREMIUM DUE DATES

The Policy Effective Date and the first day of each succeeding modal period.

Premium rates are subject to change in accordance with the Changes in Premium Rates provision of the *Administrative Provisions* section of this Policy. An Employee's premium is based on His Age and will increase on the Policy Anniversary Date after the Employee enters a new Age bracket.

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DESCRIPTION OF COVERAGES AND BENEFITS

This Description of Coverages and Benefits Section describes the Hospital Indemnity Coverages and Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits* and may be subject to a Benefit Waiting Period and/or an Elimination Period before benefits can be paid. The Benefit Amounts shown in the *Schedule of Benefits* will be paid regardless of the actual expenses incurred. Certain words capitalized in the text of these descriptions have special meanings within this Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these coverages and benefits.

HOSPITALIZATION BENEFITS

HOSPITAL ADMISSION

We will pay the per day Benefit Amount shown in the *Schedule of Benefits*, subject to the following conditions and limitations, if the Covered Person is admitted to and confined in a Hospital due to a Covered Injury or Covered Illness. This benefit will pay in addition to the Hospital Chronic Condition Admission Benefit, Hospital Stay and/or Hospital Intensive Care Unit Stay Benefit.

Benefit Conditions

1. The Hospital stay is as an Inpatient, as defined by the policy.

Benefit Limitation

This benefit will not be payable if:

1. Treatment is given only in the emergency room.
2. Treatment is provided on an Outpatient basis.
3. Treatment is for Hospital re-admission for the same Covered Injury or Covered Illness.
4. The benefit is limited to 1 Hospital admission per 90 days whether for the same or different Covered Injury or Covered Illness.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

HOSPITAL CHRONIC CONDITION ADMISSION

We will pay the per day Benefit Amount shown in the *Schedule of Benefits*, subject to the following conditions and limitations, if the Covered Person is admitted to and confined in a Hospital due to a Chronic Condition as specified in the Definitions section of the Policy. This benefit will pay in addition to the Hospital Admission, Hospital Stay or Hospital Intensive Care Unit Stay Benefit.

Benefit Conditions

1. The Hospital stay is as an Inpatient, as defined by the policy; and
2. Treatment, including an evaluation or consultation, for a Chronic Condition is provided by a specialist in that field of medicine.

Benefit Limitation

This benefit will not be payable if:

1. Treatment is given only in the emergency room.
2. Treatment is provided on an Outpatient basis.
3. Treatment is for Hospital re-admission for the same Covered Injury or Covered Illness.
4. The benefit is limited to 1 Hospital admission per 90 days whether for the same or different Covered Injury or Covered Illness.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

HOSPITAL STAY BENEFIT

We will pay per day the Benefit Amount shown in the *Schedule of Benefits*, subject to the following conditions and limitations, if the Covered Person is confined in a Hospital due to a Covered Injury or Covered Illness. Benefits are payable for up to the Maximum Benefit Period shown in the *Schedule of Benefits*.

Benefit Conditions

The Hospital Stay must meet all of the following:

1. Must be at the direction and under the care of a Physician; and
2. Must be admitted on an Inpatient basis.

The benefit will be paid for each day of a continuous Hospital Stay. If the Hospital Stay begins during the Benefit Waiting Period, the benefit will be paid for each continuous day that extends after the end of the Elimination Period, as shown in the *Schedule of Benefits*. If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.

Benefit Limitations

1. The benefit is limited to 1 Hospital Stays within a 90 day period.
2. If a benefit is payable under the Hospital Stay Benefit as well as under the Hospital Intensive Care Unit Stay Benefit, only 1 benefit will be paid for the same Covered Injury or Covered Illness, whichever is the greater amount.
3. If the Covered Person leaves the Hospital and then returns within 90 days for the same or a related Covered Injury or Covered Illness, we will still count that as one Hospital Stay. However, if the Covered Person is out of the Hospital for at least 90 days and then returns for the same or a related Covered Injury or Covered Illness, we will count that as a different Hospital Stay.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

HOSPITAL INTENSIVE CARE UNIT (ICU) STAY BENEFIT

We will pay per day the Benefit Amount shown in the *Schedule of Benefits*, subject to the following conditions and limitations, if the Covered Person is confined in an ICU of a Hospital due to a Covered Injury or Covered Illness. Benefits are payable for up to the Maximum Benefit Period shown in the *Schedule of Benefits*.

Benefit Conditions

The Hospital ICU Stay must meet all of the following:

1. Must be at the direction and under the care of a Physician; and
2. Must be admitted on an Inpatient basis.

The benefit will be paid for each day of a continuous Hospital ICU Stay. If the Hospital ICU Stay begins during the Benefit Waiting Period, the benefit will be paid for each continuous day that extends after the end of the Elimination Period, as shown in the *Schedule of Benefits*. If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.

Benefit Limitations

1. The benefit is limited to 1 Hospital ICU Stays within a 90 day period.
2. If a benefit is payable under the Hospital Stay Benefit as well as under the Initial Hospital Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Injury or Covered Illness, whichever is the greater amount.
3. If the Covered Person leaves the Hospital ICU and then returns within 90 days for the same or a related Covered Injury or Covered Illness, we will still count that as one Hospital ICU Stay. However, if the Covered Person is out of the Hospital ICU for at least 90 days and then returns for the same or a related Covered Injury or Covered Illness, we will count that as a different Hospital ICU Stay.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

HOSPITAL OBSERVATION STAY BENEFIT

We will pay the per day Benefit Amount shown in the *Schedule of Benefits*, subject to the following conditions and limitations, if the Covered Person receives treatment for a Covered Injury or Covered Illness in a Hospital, including an observation room, or an Ambulatory Surgical Center, for a period in excess of 24 hours on a non-Inpatient basis and a charge is incurred.

Benefit Conditions

The Hospital Observation Stay must meet all of the following:

1. Be at the direction and under the care of a Physician.

Benefit Limitations

1. This benefit is not payable if a benefit is payable under the Hospital Stay Benefit or Hospital Intensive Care Unit Stay Benefit.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

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GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Active Service

An Employee will be considered in Active Service with His Employer on any day that is either:

1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.

A Covered Person is not considered in Active Service if he is:

1. Inpatient in a Hospital, receiving Hospice Care or confined in a rehabilitation or convalescence center or receiving Outpatient care for chemotherapy or radiation therapy;
2. confined at home under the care of a Physician for Illness or Injury;
4. receiving disability benefits from any source due to his or her Illness or Injury, Totally Disabled; or
5. unable to perform any of the activities of daily living (i.e. mobility, transferring, feeding, dressing, toileting,) without human supervision or assistance.

Age

A Covered Person's Age, for purposes of premium calculations, is His Age attained on the date coverage becomes effective for Him under this Policy. A Covered Person's Age, for purposes of changes in rates due to age or age-based terminations is his Age on the Policy Anniversary Date coinciding with or following the Covered Person's birthday. For all other purposes, a Covered Person's Age is his Age as of his last birthday.

Benefit Waiting Period

The period of time, shown in the *Schedule of Benefits*, immediately following the effective date of the Covered Person's coverage. No benefits will be paid under the *Schedule of Benefits* for Hospital Indemnity Benefits or any Additional or Optional Benefits for a covered event or a Covered Loss that occurs during the Benefit Waiting Period.

Certificate

The Certificate, including the Certificate Schedule, amendments, riders and supplements, if any, is a written statement prepared by us to set forth a summary of:

1. benefits to which the covered person is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

Chronic Condition

A condition that:

1. has been diagnosed and treated during a Hospital Stay for which benefits are payable; and
2. Is any of the following conditions:
 - a. asthma, chronic obstructive pulmonary disease (COPD), emphysema and chronic bronchitis
 - b. low back pain, metabolic syndrome, osteoarthritis, peripheral arterial disease, behavioral: anxiety, bipolar disorder, depression
 - c. diabetes mellitus: Type 1, Type 2
 - d. cardiac concerns: acute myocardial infarction, angina, congestive heart failure, coronary artery disease, heart disease.

Complications of Pregnancy	<p>Whether or not the pregnancy is terminated, any condition:</p> <ol style="list-style-type: none"> 1. that requires hospital confinement; and 2. whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. <p>Examples include: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar conditions of comparable severity, non-elective caesarean section; ectopic pregnancy which is terminated; and spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible.</p> <p>Complications of pregnancy do not include: false labor; occasional spotting; physician prescribed rest during pregnancy; morning sickness; hyperemesis gravidarum; pre-eclampsia; and similar conditions associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy.</p>
Covered Illness	A physical or mental disease or disorder including pregnancy and Complications of Pregnancy, that results in a Covered Loss. A Covered Illness includes medically-necessary quarantine in a Hospital in conjunction with medically-necessary preventive treatment due to an identifiable exposure to a life-threatening contagious and infectious disease.
Covered Injury	Any bodily harm that results directly from a Covered Loss.
Covered Loss	<p>A loss that is:</p> <ol style="list-style-type: none"> 1. a benefit specified in the <i>Schedule of Benefits</i>. 2. suffered by the Covered Person within the applicable time period specified in the <i>Schedule of Benefits</i>.
Covered Person	An eligible person, as defined in the <i>Schedule of Benefits</i> , who is enrolled and for whom Evidence of Insurability, where required, has been accepted by Us, required premium has been paid when due and coverage under this Policy remains in force.
Dependent Child	<p>An Employee's child who meets the following requirements:</p> <ol style="list-style-type: none"> 1. A child from live birth to the end of the year in which the child attains age 26; 2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. <p>A child, for purposes of this provision, includes an Employee's:</p> <ol style="list-style-type: none"> 1. natural child; 2. adopted child, beginning with date of the filing of the petition for adoption. It also means the legally adopted child of the Employee's Spouse provided the child is living with, and is financially dependent upon the Employee; 3. stepchild who resides with the Employee and is financially dependent upon the Employee; 4. child for whom the Employee is the court-appointed legal guardian and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.
Eligibility Waiting Period	The cumulative period of time during a continuous period of employment that an Employee must be in Active Service in order to be eligible for coverage under the Policy. It will be extended by the number of days the Employee is not in Active Service.
Elimination Period	The continuous period of time that must be satisfied before a benefit shown in the <i>Schedule of Benefits</i> is payable. An Elimination Period may be satisfied during the Policy's Benefit Waiting Period.

Emergency Room	A designated area in a Hospital that is supervised by Physicians and equipped and staffed to render immediate medical attention on an outpatient basis, 24 hours a day, 7 days a week for the sudden onset of symptoms related to a Covered Injury or Covered Illness. An Emergency Room is not a clinic, an Urgent Care Facility or Physician's office.
Employee	For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.
Employer	The Subscriber and any affiliates, subsidiaries or divisions shown in the <i>Schedule of Affiliates</i> and which are covered under this Policy on the date of issue or subsequently agreed to by Us.
Full-time	Full-time means the number of hours set by the Subscriber as a regular work week for Employees in the Employee's eligibility class.
He, His, Him, Himself	Refers to any individual, male or female.
Hospice Care	Care provided at a designated facility by licensed health care professionals primarily engaged in providing medical services, emotional support, and spiritual resources for people who are in the last stages of a terminal illness.
Hospital	<p>An institution that meets all of the following:</p> <ol style="list-style-type: none"> 1. It is licensed as a Hospital pursuant to applicable law; 2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons; 3. It is managed under the supervision of a staff of Physicians; 4. It provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and 5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis. <p>The term Hospital does not include a clinic, facility, or unit of a Hospital for:</p> <ol style="list-style-type: none"> 1. Rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care; 2. The aged, drug addicts or alcoholics; or 3. A facility primarily or solely providing psychiatric services to mentally ill patients.
Illness	A physical or mental disease or disorder including pregnancy. An illness includes medically-necessary quarantine in a Hospital in conjunction with medically-necessary preventive treatment due to an identifiable exposure to a life-threatening contagious and infectious disease.
Initial Open Enrollment Period	The period during a calendar year when an eligible Employee who was hired on or before the Policy Effective Date may enroll for the first time for coverage under this Policy. This period must be agreed upon by the Employer and Us.
Injury	Any accidental loss or bodily harm.
Inpatient	A Covered Person who is charged and confined for at least one full day's Hospital room and board.
Insurability Requirement	Evidence of good health that is submitted by the Eligible Person and is satisfactory to Us before the coverage subject to this requirement becomes effective. An eligible person satisfies the insurability requirement on the day We agree in writing to accept him as insured for the amount subject to this requirement. We may require that the evidence of good health be provided at the eligible person's expense.

Intensive Care Unit (ICU)	<p>A designated area of a hospital that:</p> <ol style="list-style-type: none"> 1. is for the treatment of patients who are in acute or critical condition; 2. is furnished with emergency life-saving equipment and supplies that are immediately at hand; 3. is staffed 24 hours a day by Nurses who are specially trained to work in an intensive care unit; 4. is equipped and staffed to monitor each patient's vital signs around-the-clock; and 5. is not a recovery room or an area used primarily for post-operative or post-anesthesia care. <p>An Intensive Care Unit includes a critical care or cardiac care unit.</p>
Mental Illness and Nervous Disorder	<p>Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, regardless of cause, without demonstrable organic disease, where improvement can reasonably be anticipated with therapy.</p>
Nurse	<p>A licensed graduate registered Nurse (R.N.), a licensed practical Nurse (L.P.N.), or a licensed vocational Nurse (L.V.N.) who is not:</p> <ol style="list-style-type: none"> 1. employed or retained by the Subscriber; 2. living in the Covered Person's household; or 3. a parent, sibling, spouse or child of the Covered Person.
Outpatient	<p>A Covered Person who receives medical tests, treatment, or services from an Ambulatory Surgical Center, Hospital, lab, medical clinic, Physician's office, or radiologic center and is not confined for a day's room and board.</p>
Part-Time	<p>Regularly working the number of hours set by the Subscriber as a regular work week for Employees, other than Full-Time, temporary or seasonal, in the Employee's eligibility class.</p>
Physician	<p>A licensed medical, osteopathic or podiatric practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer medication and to perform surgery that is appropriate for the condition and locality and who is not:</p> <ol style="list-style-type: none"> 1. employed or retained by the Subscriber; 2. living in the Covered Person's household; or 3. a parent, sibling, spouse or child of the Covered Person.
Spouse	<p>The Employee's lawful spouse who is at least Age 18 but not yet Age 100. Except for purposes of determining initial eligibility, the term includes a spouse who is widowed or divorced or legally separated from an Employee.</p>
Subscriber	<p>Any participating organization that subscribes to the Trust to which this Policy is issued.</p>
Totally Disabled or Total Disability	<p>Either:</p> <ol style="list-style-type: none"> 1. inability of the Covered Person who is currently employed by the Employer to do any type of work for which he is or may become qualified by reason of education, training or experience; or 2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

Trust

The Group Insurance Trust for Employers named on the face page of this Policy.

**We, Us, Our,
Insurance Company**

Life Insurance Company of North America.

GHIP-00-1200.00

ELIGIBILITY

Employee

An Employee becomes eligible for coverage under this Policy on the date He meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits*. The Eligibility Waiting Period will not apply to an Employee, in Active Service on the Policy Effective Date, who was covered under the Prior Plan and satisfied the Eligibility Waiting Period, if any, of that plan. Credit will be given for any time that was satisfied.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if coverage ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed by the Employer, and within one year becomes a member of an eligible class.

Spouse and Dependent Children

A Spouse and Dependent Children of an eligible Employee become eligible for any dependent coverage provided by this Policy on the later of the date the Employee becomes eligible or the date the Spouse or Dependent Child meets the applicable definition shown in the *General Definitions* section of this Policy. The Employee must be insured under the Policy in order to elect coverage for a Spouse or Dependent Child. An eligible person may be insured only once as of any given date under the Policy as a Covered Person, even though He may be eligible under more than one class of insureds.

ENROLLMENT

An eligible Employee may apply for coverage, subject to the *Deferred Effective Date Provisions* section of this Policy, for Himself or any eligible Spouse or Dependent Child or to increase coverage for any Covered Person under this Policy during the Initial Open Enrollment Period as agreed to by Us and the Subscriber.

An eligible Employee must be insured for coverage for which He is required to contribute to the cost of insurance in order to apply for coverage for an eligible Spouse or Dependent Child.

During the Initial Open Enrollment Period, an Employee and His eligible Spouse or Dependent Child may become insured under the coverage provided by this Policy without satisfying any Evidence of Insurability. Any Employee who is not in Active Service on the date His coverage would otherwise become effective under this Policy may not become covered under this Policy until He returns to Active Service.

If an Employee's eligible dependent is not in Active Service on the date the coverage would otherwise be effective, it will be effective on the date the dependent returns to Active Status.

EFFECTIVE DATE PROVISIONS

Policy Effective Date

Coverage begins on the Policy Effective Date shown on this Policy's first page as long as the Minimum Participation Requirements shown in the *Schedule of Benefits* have been satisfied.

Subscriber Effective Date

Coverage for the Subscriber becomes effective on the Effective date of Subscriber Participation as long as the Minimum Participation Requirements shown in the *Schedule of Benefits* have been satisfied.

Effective Date for Individuals (*Newly Eligible and Life Status*)

Voluntary Benefit

For all Employee coverage, Evidence of Insurability is not required.

If the Employee applies for coverage and agrees to make required contributions within 31 days after the date He becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the first of the month following the date We or the Employer receive the Employee's completed enrollment form.

For all Spouse coverage, Evidence of Insurability is not required.

If the Spouse is eligible for coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Spouse becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Spouse as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form.

For all Dependent Child coverage, Evidence of Insurability is not required.

If the Dependent Child is eligible for coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Dependent Child becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Dependent Child as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form for Dependent Child coverage.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date the child qualifies as a Dependent Child.

Effective Date of Changes

Any increase or decrease in the amount of coverage for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class, will take effect on the date of such change. Increases will take effect subject to any Active Service requirement.

DEFERRED EFFECTIVE DATE PROVISIONS

Active Service

The effective date of coverage will be deferred for any Employee or any eligible Spouse or Dependent Child who is not in Active Service on the date insurance would otherwise become effective. Coverage will become effective on the later of the date He returns to Active Service, or the date coverage would otherwise have become effective.

Annual Re-Enrollment and Life Status Change

An Annual Re-Enrollment is a period of time once per year, no more than twice per year as agreed to by Us and the Subscriber when an Employee can apply for coverage or to increase coverage on Himself, Spouse or Dependent Child under this Policy.

Life Status Change

A Life Status Change is an event that the Employer has determined qualifies an Employee to apply for coverage or to increase coverage on Himself, His Spouse or Dependent Child due to a Life Status Change under this Policy.

Life Status Changes that qualify an Employee to apply or increase coverage for Himself include:

1. marriage;
2. loss of a spouse; whether by death, divorce, annulment or legal separation;
3. birth or adoption of a child, or acquiring a child through marriage;
4. a change in the group benefit plan available to the Employee's Spouse;
5. a change in the Employee's employment status that affects eligibility for group benefits for either the Employee or His Spouse;
6. termination of a Spouse's employment; and
7. as specified in the Employer's Plan which this Policy insures.

Life Status Changes that qualify an Employee to apply or increase coverage for His eligible Spouse and Dependent Child include:

1. marriage;
2. loss of a spouse; whether by death, divorce, annulment or legal separation;
3. birth or adoption of a child, or acquiring a child through marriage;
4. a change in the group benefit plan available to the Spouse;
5. a change in the Spouse's employment status that affects eligibility for group benefits for either the Employee or His Spouse;
6. termination of a Spouse's employment; and
7. as specified in the Employer's Plan which this Policy insures.

Annual Re-Enrollment

An Employee who is eligible to apply, but did not previously enroll, may apply or is insured may apply for an increase for coverage. Changes to coverage for an Employee who applies during the enrollment period and agrees to make required contributions 31 days after enrollment period ends are as follows:

The Employee may apply for an increase in coverage on an insured Spouse or for coverage on a Spouse who is eligible to be insured but was not previously enrolled by the Employee.

The Dependent Child who is eligible to apply, but was not previously enrolled by the Employee, the Employee may apply or is insured the Employee may apply for an increase for coverage.

For all Employee, Spouse and Dependent Child coverage, Evidence of Insurability is not required.

Coverage for which an Employee, Spouse and Dependent Child is eligible will be effective on the effective date of this Policy's anniversary following the enrollment period.

TERMINATION OF INSURANCE

The coverage on a Covered Person will end on the earliest date below:

1. the date this Policy or coverage for a Covered Class is terminated.
2. the date the Subscriber's participation under this Policy ends.
3. the date the Employee is no longer in Active Service.
4. the next premium due date after the date the Employee is no longer in a Covered Class or satisfies eligibility requirements under this Policy.
5. the last day of the last period for which premium is paid.
6. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy, as shown in the *Schedule of Benefits*.
7. with respect to a Spouse or Dependent Child, the date of the death of the covered Employee or the date of divorce from the covered Employee, unless the Spouse elects to continue coverage, including coverage on any Dependent Child. See the *Continuation of Insurance Provisions* section.
8. for a Spouse, the date the Spouse reaches age 100.
9. for a Dependent Child, the end of the year in which the Dependent Child reaches age 26, unless primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Injury or Covered Illness that occurs while coverage was in effect.

CONTINUATION OF INSURANCE PROVISIONS

If an Employee is no longer in Active Service, coverage may be continued. The following provisions explain the continuation options available under this Policy. Please see the *Schedule of Benefits*, to determine the applicability of these benefits on a class level.

Notwithstanding any other provision of this Policy, if an Employee's Active Service ends due to termination of employment, or any other termination of the employment relationship, coverage will end and Continuation of Insurance under this section will not apply.

If an Employee's Active Service ends due to personal or family medical leave approved timely by the Employer, coverage will continue for up to the Maximum Benefit Period as shown in the *Schedule of Benefits* for family medical leave. Premiums are required for this coverage and are to be remitted directly to the Subscriber.

If an Employee's Active Service ends due to sabbatical leave approved timely by the Employer, coverage will continue for up to the Maximum Benefit Period as shown in the *Schedule of Benefits* for family medical leave. Premiums are required for this coverage and are to be remitted directly to the Subscriber.

If an Employee's Active Service ends due to a leave due to disability approved timely by the Employer, coverage will continue for up to the Maximum Benefit Period as shown in the *Schedule of Benefits* for family medical leave. Premiums are required for this coverage and are to be remitted directly to the Subscriber. (*Applicable to Class 2 only.*)

If an Employee's Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date the Employee ceases work, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. Premiums are required for this coverage and are to be remitted directly to the Subscriber. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Illness which is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* section:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. declared or undeclared war or act of war;
4. a Covered Injury or Covered Illness that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
5. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
6. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Injury or Covered Illness occurred.
7. those not necessary, as determined by Us in accordance with generally accepted standards of medical practice, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed, recommended, or approved by the attending physician.
8. elective or cosmetic surgery. This does not include reconstructive, cosmetic surgery: a) incidental to or following surgery for trauma, infection or other disease of the involved part; or b) due to congenital disease or anomaly of a Covered Dependent child which has resulted in a functional defect.
9. dental surgery, unless the surgery is the result of an accidental injury;
10. services or treatment rendered by a Physician, Nurse or any other person who is:
 - a. employed or retained by the Subscriber;
 - b. providing homeopathic, aroma-therapeutic or herbal therapeutic services
 - c. living in the Covered Person's household;
 - d. a parent, sibling, spouse or child of the Covered Person.

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CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic, or telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as is reasonably possible. If written or authorized electronic, or telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic, or telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Subscriber's name and Policy number and your name, address, Policy and Certificate number.

Claim Forms

We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision

Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 120 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than 60 days upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under the Policy are payable to the Covered Person, if living, except if the Covered Person is a Dependent Child, then the benefits will be payable to the Employee. If the Covered Person dies while any of these benefits remain unpaid, benefits payable under the Policy will be paid to the Covered Person's Spouse, if living, or otherwise to the executors or administrators of the Covered Person's estate.

Benefits will be reduced by any outstanding premium due.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay \$1,000 to a relative by blood or marriage whom We believe is equitably entitled.

Any payment made by Us in good faith pursuant to this provision will fully discharge Us, and release Us from all liability, to the extent of such payment.

Physical Examination and Autopsy

We, at Our own expense, have the right and opportunity to examine You, Your Spouse and Dependent Child when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when You or the Covered Person dies, We may recover the overpayment from Your or the Covered Person's estate.

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ADMINISTRATIVE PROVISIONS

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates determined by written agreement between the Subscriber and Us, the plan and amounts of insurance in effect.

Payment of Premium

Covered Person

You, Your Spouse and Dependent Child may be responsible for the payment of premium directly to Us, as determined by the Employer from the Policy Effective Date, or following the expiration of 60 days from the date coverage is continued for You, Your Spouse and Dependent Child under the *Continuation of Insurance Provisions* section of the Policy. Premium shall be due monthly, unless the You, Your Spouse and Dependent Child and We agree on some other period for premium payment. If premium is not paid when due, coverage will end as of the premium due date, except as provided in the Covered Person Grace Period provision below.

Grace Period

Covered Person

A Grace Period of 31 days will be granted for payment of required premiums under this Policy. Your, Your Spouse and Dependent Child's coverage under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, coverage will end on the last day of the period for which premiums were paid.

Reinstatement of Insurance

If Your Active Service ended due to an approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, Your coverage may be reinstated at the conclusion of the FMLA leave.

If Your Active Service ends due to the Employer-approved unpaid leave of absence, other than an approved FMLA leave, coverage may be reinstated only:

1. if the reinstatement occurs within 12 weeks from the date insurance ends; or
2. when returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

Effective Date of Reinstated Insurance

Reinstated coverage will be effective on the date You return to Active Service. If You did not fully satisfy the Eligibility Waiting Period, Benefit Waiting Period, or the Pre-Existing Condition Limitation (if any) before coverage ended due to an approved unpaid leave of absence or Temporary Layoff, credit will be given for any time that was satisfied.

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GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of coverage. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Misstatement of Age or Sex

If the Covered Person's age or sex has been misstated, the benefits payable under this Policy will be reduced under the Payment of Claims provision of the Policy.

Certificates

Where required by law, We will provide a Certificate for delivery by the Subscriber to the Covered Person. Each Certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

Multiple Certificates

The Covered Person may have in force only one Certificate at a time under this Policy. If at any time the Covered Person has been issued more than one Certificate, then only the Certificate insuring the Covered Person as an Employee shall be in effect. We will refund premiums paid for the others for any period of time that more than one Certificate was issued.

A Covered Person is not eligible for coverage under more than one Certificate providing similar benefits for coverage under group policies issued by Us. If premium is being paid for more than one such Certificate as an Employee or a Dependent, then coverage will be in effect under the Certificate with the earliest effective date and premiums paid for Certificates which are not in effect will be refunded.

Assignment

The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Loss. Any other attempt to assign will be void.

Incontestability

This Policy or Participation Under This Policy

All statements made by the Subscriber to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Subscriber.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud or lack of eligibility for coverage.

A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person's effective date of coverage, or from the effective date of increased benefits, no such statement will cause coverage or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Policy Termination

We may terminate coverage on or after the first anniversary of the Policy Effective Date. We or the Subscriber may terminate coverage on any Premium Due Date. Written notice by certified mail must be given at least 31 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Injury or Covered Illness that is the result, directly of a Covered Loss that occurs while coverage was in effect.

Agency

The Employer is acting as an agent of the Employee for transactions relating to insurance under the Policy. The actions of the Subscriber shall not be considered the actions of the Insurance Company, and We are not liable for any of their acts or omissions.

Clerical Error

A Covered Person's coverage will not be affected by error or delay in keeping records of coverage under this Policy. If such an error is found, the premium will be adjusted fairly. A failure to perform, including perform in a timely manner or in a manner prescribed by the Policy, any of the following shall not constitute a clerical error under this provision:

1. enroll or apply for coverage;
2. submit evidence of insurability;
3. report notice or provide proof of claim;
4. pay premiums.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Policy Changes

We may agree with the Subscriber to modify coverage without the Covered Person's consent.

Workers' Compensation Insurance

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

Examination of the Policy

This Policy will be available for inspection at the Subscriber's or Our office during regular business hours.

Examination of Records

We will be permitted to examine all of the Subscriber's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force. Examination may also occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all claims under this Policy.

Ownership of Records

All records maintained by Us are, and shall remain, Our property.

GCI-00-CE1800.00

MODIFYING PROVISIONS AMENDMENT

Subscriber: University of Richmond

Policy No.: HC960598

Amendment Effective Date: January 01, 2020

This Amendment is attached to and made part of this Policy. Its provisions are intended to conform this Policy to the laws of the state in which the insured resides.

Subscriber and We hereby agree that the Policy and any Certificates delivered under the Policy are amended as follows:

Arkansas residents:

- 1) Under the *General Definitions* section, item 2 of the second paragraph of the definition of Dependent Child is replaced with the following:
 2. adopted child, *under the charge, care and control of the insured who has filed a petition for adoption*, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of the Employee's Spouse provided the child is living with, and is financially dependent upon the Employee;

Indiana residents

- 1) Under the *Claim Provisions* section, the Notice of Claim and Payment of Claims provisions are updated as follows:

Notice of claim must be received within 90 days after a Covered Loss occurs or begins.

Payment of Claims - The following language added to the Payment of Claims Provision:

Indemnities payable under this Policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. If We are unable to immediately pay due to deficiencies in Your claim, We will notify You within 30 days if Your claim was filed electronically or within 45 days if Your claim was filed on paper of those deficiencies and how they can be remedied. Our failure to notify You of any deficiencies within the stated time frames will establish the submitted claim as a clean claim. We will pay or deny a clean claim:

1. If filed electronically, within 30 days after the date We receive the claim;
2. If the claim is filed on paper, within 45 days after the date We receive the claim.

Louisiana residents:

1) Under the *General Definitions* section, the following changes are made:

a. The Dependent Child definition is replaced by the following:

Dependent Child An Employee's natural child, stepchild, foster child, legally adopted child, child of adopting parents pending finalization of adoption procedures, and child for whom coverage has been court-ordered, as follows:

1. unmarried child from live birth under 26 years of age;
2. unmarried grandchild under 26 years of age who is in the Employee's legal custody and residing in the Employee's home;
3. the otherwise applicable limiting age shown above shall not apply to the Employee's unmarried child or grandchild who is incapable of self-support due to a mental or physical incapacity.

Any unmarried child who is placed in the Employee's home pursuant to an adoption placement agreement executed with a licensed adoption agency shall be considered a Dependent Child of the Employee from the date of placement in the Employee's home.

Any unmarried child who is placed in the Employee's home following execution of an act of voluntary surrender in favor of the Employee or the Employee's legal representative shall be considered a Dependent Child of the Employee effective on the date on which the act of voluntary surrender becomes irrevocable.

b. The Hospital definition is replaced by the following:

Hospital An institution that meets all of the following:

1. It is licensed as a Hospital pursuant to applicable law;
2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. It is managed under the supervision of a staff of Physicians;
4. It provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and
5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis.

c. The Physical Therapy definition is replaced by the following:

Physical Therapy Manipulation by physical and mechanical means including heat treatment or diathermy, ultrasonic, microtherm, manipulation, adjustment, massage therapy and acupuncture as performed by a licensed Physical Therapist, licensed chiropractor or licensed podiatrist.

2) Under the *Administrative Provisions* section, the first paragraph of the Changes in Premium Rates provision is updated as follows:

Changes in Premium Rates:

The premium rates may be changed by Us from time to time with at least 31 days advance written notice, and 45 days advance written notice for rates increase of 20% or more. No change in rates will be made until 24 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, We reserve the right to change the rates even during a period for which the rate is guaranteed, if any of the following events take place:

- 3) Under the *General Provisions* section, make the following changes:

Under Incontestability provision, the time limit changed from two years to three years as shown below:

This Policy or Participation Under This Policy

After three years from the Policy Effective Date, no such statement will cause this Policy to be contested except for lack of eligibility for coverage

Under Policy Termination, the time period changed from 31 days to 60 days as shown below:

Policy Termination:

We may terminate coverage on or after the first anniversary of the Policy Effective Date. We or the Subscriber may terminate coverage on any Premium Due Date. Written notice by certified mail must be given at least 60 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid

Maine residents:

- 1) Add the following renewal disclaimer to the *Face Pages* of the Policy and Certificate:

RENEWAL SUBJECT TO CONSENT OF COMPANY: PLEASE READ TERMINATION OF POLICY PROVISION IN THE GENERAL PROVISIONS SECTION.

Add Medicare Supplement provision to the face page as shown below:

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

- 2) Under the *Eligibility, Enrollment, Effective Date Provisions*, the following Third Party Notice of Cancellation provision is added:

Third Party Notice of Cancellation

You have the right:

1. to designate a third party to receive notice of cancellation of Your Certificate;
2. to change such designation; and
3. of Certificate reinstatement, if You suffer from Cognitive Impairment or Functional Incapacity and the grounds for cancellation was nonpayment of premium or other lapse or default on Your part.

We will send You a Third Party Notice Request Form. We will do this within 10 days of receiving Your request. Any time after completion of this form You may change this designation by written request.

After We have received Your completed Third Party Notice Request Form, at least 10 days prior to cancellation of Your Certificate, We will give notice of the pending cancellation to Your designated third party, if any, at the address You provided. This notice will give the reason for the cancellation. It will also give the date the Certificate is to end. Cancellation may be due to nonpayment of premium. If so, the notice will include the amount of unpaid premium and the date by which it must be paid. The cancellation may be due to some other lapse or default on Your part. If so, the notice will include an explanation of how to cure the default and the time You have to do this.

You may be able to reinstate this Certificate. This is the case if it is cancelled for nonpayment of premium on the basis that You suffered from Cognitive Impairment or Functional Incapacity at the time of cancellation. To do this, You, any person authorized to act on Your behalf or any dependent of Yours who is covered under the Policy may request reinstatement. This must be done within 90 days of the date of cancellation.

We may request a medical demonstration that You suffered from Cognitive Impairment or Functional Incapacity at the time of cancellation. The medical demonstration, if requested, must be provided at Your expense. If the demonstration is waived or substantiates the existence of Cognitive Impairment or Functional Incapacity at the time of cancellation to Our satisfaction, Your Certificate will be reinstated. This will be subject to the following:

1. Your Certificate will be reinstated without evidence of insurability; and
2. Your reinstated coverage will cover loss occurring from the date of cancellation. There will be no gap in coverage. Benefits under the Policy will be at the level provided immediately before the cancellation.
3. The premium for the reinstated coverage must be paid from the date of the last premium payment. This will be at the rate which would have been in effect had coverage remained in force. You must pay this premium within 15 days of Our request for the premium.

The Subscriber's coverage under the Policy may be cancelled as a result of the responsible party's Cognitive Impairment or Functional Incapacity. If so the Subscriber has the right to reinstate coverage. This can be done in the same manner and subject to the same limitations as described in the prior paragraphs. This does not limit Our right to cancel the Subscriber's coverage, on the grounds that the Subscriber is no longer in business, even if the cessation of business results from the responsible party's Cognitive Impairment or Functional Incapacity. We must give sufficient notice before We do this.

For the purpose of this provision, "Cognitive Impairment or Functional Incapacity" means a mental or nervous disorder with a demonstrable organic origin causing significant cognitive impairment, including but not limited to Pick's Disease, Parkinson's Disease, Huntington's Chorea and Alzheimer's Disease and related dementia.

- 3) Under the *Administrative Provisions* section, add the Changes in Premium Rates to the Certificate:

Changes in Premium Rates

The premium rates may be changed by Us from time to time with at least 31 days advance written notice. No change in rates will be made until 24 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, We reserve the right to change the rates even during a period for which the rate is guaranteed, if any of the following events take place:

1. The Policy terms change.
2. A division, subsidiary, eligible company, or class is added or deleted.
3. There is a change of more than 10% in the number of eligible Employees.
4. Federal or state laws or regulations affecting benefit obligations change.
5. Other changes occur in the nature of the risk that would affect Our original risk assessment.
6. We determine the Employer fails to furnish necessary information.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

- 4) Under the *General Provisions* section, the following changes have been made:

Under Incontestability provision, the time limit changed from two years to three years and reference to fraud removed as shown below:

This Policy or Participation Under This Policy

After three years from the Policy Effective Date, no such statement will cause this Policy to be contested except for lack of eligibility for coverage

Under Incontestability provision, reference to fraud removed as shown below:

A Covered Person's Insurance

After two years from the Covered Person's effective date of coverage, or from the effective date of increased benefits, no such statement will cause coverage or the increased benefits to be contested except for lack of eligibility for coverage.

Massachusetts residents:

Under the *Continuation of Insurance Provisions* section, the following provision is added:

Additional Continuation of Insurance Provisions

If an Employee leaves the group due to termination of employment resulting from a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:

1. 90 days from the date of the Plant Closing or Partial Closing;
2. The date the Employee becomes eligible for similar benefits.

As used in this provision:

"Plant Closing" means a permanent cessation or reduction of business at a facility which results or will result as determined by the director in the permanent separation of at least 90% of the employees of said facility within a period of six months prior to the date of certification or with such other period as the director shall prescribe, provided that such period shall fall within the six month period prior to the date of certification.

"Partial Closing" means a permanent cessation of a major discrete portion of the business conducted at a facility which results in the termination of a significant number of the employees of said facility and which affects workers and communities in a manner similar to that of Plant Closings.

If an Employee leaves the group for a reason other than as a result of a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:

1. 31 days from the date the Employee leaves the group;
2. The date the Employee becomes eligible for similar benefits.

Minnesota residents:

- 1) Under the *Common Exclusions* section, the following changes are made:

Modify the following exclusions as shown:

1. intentionally self-inflicted Injury;
2. commission or attempt to commit a felony;
6. operating any type of vehicle while under the influence of alcohol or any drug or narcotic unless administered on the advice of a Physician and taken in accordance with the prescribed dosage or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Injury or Covered Illness occurred;

Mississippi residents:

- 1) Under the *Claim Provisions* section, the following changes apply:

Time of Payment of Claims is replaced by the following:

Time of Payment of Claims

Claims will be paid within 25 days of completed proof of loss in the form of a clean claim where claims are submitted in paper format; if not paid within applicable time period, interest is due at the rate of 1½ % per month accruing from day after payment was due until paid.

Physician Examination and Autopsy is replaced by the following:

Physical Examination

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending.

- 2) Under the *Administrative Provision* section, the following changes apply:

Under Changes in Premium Rates, the time period changed from 31 days to 60 days as shown below:

Changes in Premium Rates

The premium rates may be changed by Us from time to time with at least 60 days advance written notice.

- 3) Under the *General Provisions* section, Misstatement of Age or Sex provision and Conformity with Statutes provision are replaced by the following:

Misstatement of Age

If the Covered Person's age has been misstated, the benefits payable under this Policy shall be as such as the premium paid would have purchased had such fact been correctly stated.

Conformity to State Statutes

Any provisions in conflict with the requirements of the state in which the insured resides that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

New Hampshire residents:

- 1) Under the *General Definitions* section, the following change was made:

- a. Definition of *Benefit Waiting Period* must be removed for Hospital Indemnity Benefits.
- b. Definition of *Covered Accident* cannot make reference to an "external" event.
- c. Definition of *Dependent Child* must be modified to comply with state requirements as shown below:

Dependent Child An Employee's child who meets the following requirements:

- 1. A child from live birth to 26 years old;
- 2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap.

A child, for purposes of this provision, includes an Employee's:

- 1. natural child;
- 2. adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of the Employee's Spouse provided the child is living with, and is financially dependent upon the Employee;
- 3. stepchild who resides with the Employee and is financially dependent upon the Employee;
- 4. child for whom the Employee is the court-appointed legal guardian and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.

- d. Definition of *Elimination Period* was revised, removing the reference to a policy Benefit Waiting Period.

- e. Definition of *Hospital* was revised, removing the requirement that a hospital be licensed as shown below:

Hospital

An institution that meets all of the following:

1. It is operated pursuant to applicable law;
2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. It is managed under the supervision of a staff of Physicians;
4. It provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and
5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care;
2. the aged, drug addicts or alcoholics; and
3. A facility primarily or solely providing psychiatric services to mentally ill patients.

- g. Definition of *Totally Disabled or Total Disability* was revised as follows:

**Totally Disabled
or Total Disability**

Either:

1. inability of the Covered Person who is currently employed by the Employer to do any type of work for which he is or may become qualified by reason of education, training or experience; or
2. the inability of the Covered Person who is not currently employed to perform the normal activities of a person of like age and sex and who is under the regular care of a Physician who certifies that such a person is Totally Disabled.

- 2) Under the *Claim Provisions* section, the following changes apply:

Proof of loss must be given within 90 days or when reasonably possible. A 1 year maximum is not permitted.

- 3) Under the *Administrative Provisions* section, the following changes are made:

- a. **Grace Period** – All premiums due under the policy must be remitted by the employer of the persons insured, therefore optional language permitting payment of premium directly to the Us by the employee is not permitted.

- b. The following provision must be added:

Policy Reinstatement

This Policy may be reinstated within 45 days of lapse if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Policyholder satisfactory to Us and payment of all overdue premiums. Any premiums accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

- c. **Payment of Premium**

Covered Person

You, Your Spouse and Dependent Child may be responsible for the payment of premium directly to Us, as determined by the Employer from the Policy Effective Date, or following the expiration of 60 days from the date coverage is continued for You, Your Spouse and Dependent Child under the *Portability Provisions* section of the Policy. Premium shall be due monthly, unless the You, Your Spouse and Dependent Child and We agree on some other period for premium payment. If premium is not paid when due, coverage will end as of the premium due date, except as provided in the Covered Person Grace Period provision below.

4) Under the *General Provisions* section, the following changes are made:

- a. If the *Subscriber Participation Under This Policy* provision is included in this section, the provision does not apply.
- b. *Assignment* provision - "The rights and benefits under this Policy may not be assigned to a healthcare provider" must be added to this provision.
- c. *Incontestability* provision is replaced by the following:

Incontestability

This Policy or Participation Under This Policy

All statements made by the Subscriber to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Subscriber.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for lack of eligibility for insurance or non-payment of premium.

A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person's effective date of coverage, or from the effective date of increased benefits, no such statement will cause coverage or the increased benefits to be contested except for lack of eligibility for insurance or non-payment of premium.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

- d. *Policy Termination* provision – A minimum of 45 days is required for notice of policy termination.
- e. The following *Important Notice* must be included:

Important Notice

The Subscriber may contact the Insurance Company, using the address or toll-free telephone number given below, with questions or problems with respect to this Policy:

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235
Telephone: 1.800.547.5515

North Carolina residents:

1) Under the *General Definitions* section, the following changes are made:

Active Service

An Employee will be considered in Active Service with His Employer on any day that is either:

1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury

A Covered Person is not considered in Active Service if he is:

1. Inpatient in a Hospital, receiving Hospice Care or confined in a rehabilitation or convalescence center;
2. confined at home under the care of a Physician for Illness or Injury;
3. receiving disability benefits from any source due to his or her Illness or Injury, Totally Disabled; or
4. unable to perform any of the activities of daily living (i.e. mobility, transferring, feeding, dressing, toileting,) without human supervision or assistance.

Dependent Child

An Employee's child who meets the following requirements:

1. A child from live birth to 26 years old.
2. A child who is 26 or more years old, and incapable of self-sustaining employment by reason of mental or physical handicap.

A child, for purposes of this provision, includes an Employee's:

1. natural child;
2. adopted child, foster child, beginning with any waiting period pending finalization of the child's adoption or placement. It also means the legally adopted child or foster child of the Employee's Spouse;
3. stepchild who resides with the Employee and is financially dependent upon the Employee;
4. child for whom the Employee is the court-appointed legal guardian.

Hospital

An institution that meets all of the following:

1. It is licensed as a Hospital pursuant to applicable law;
2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. It is managed under the supervision of a staff of Physicians;
4. It provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and
5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care;
2. the aged, drug addicts or alcoholics; and
3. A facility primarily or solely providing psychiatric services to mentally ill patients.

- 2) Under the *Common Exclusions* section, the following changes are made:
 - a. Modify exclusion 3:
 3. declared or undeclared war or act of war. This Exclusion does not apply to acts of terrorism;
 - b. Remove exclusion 9:
 9. Dental surgery, unless the surgery is the result of an accidental injury.
- 3) Under the *General Provisions* section, the following changes are made:
 - a. *Termination* provision:
Minimum notice must be 45 days.
 - b. *Incontestability* provision - Reference to "fraud" has been removed from statement below:
After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for lack of eligibility for coverage.

North Dakota residents:

- 1) Under the *Common Exclusions* section, the following changes are made:
 - a. Modify exclusion 2:
 2. commission or attempt to commit a felony;
- 2) Under the *Claim Provisions* section, the following changes are made:
 - a. **Notice of Claim:**
Notice of Claim must be given to Us within 20 days
 - b. **Payment of Claim:**
Under Payment of Claims provision, payment range is changed to read:

"we may pay \$1,000 to \$5,000 to a relative by blood or marriage whom We believe is equitable entitled".
- 3) Under the *Administrative Provisions* section, Effective Date of Reinstated Insurance is replaced by the following:

Effective Date of Reinstated Insurance
Reinstated coverage will be effective on the date the Employee returns to Active Service if satisfaction of the Insurability Requirement is not required. If the Insurability Requirement must be satisfied, the reinstated coverage will be effective as provided in the *Effective Date Provisions* section. If the Employee did not fully satisfy the Eligibility Waiting Period, Benefit Waiting Period, or the Pre-Existing Condition Limitation (if any, as shown in the *Schedule of Benefits* and *Description of Coverages*) before coverage ended due to an approved unpaid leave of absence or Temporary Layoff, credit will be given for any time that was satisfied.
- 4) Under the *General Provisions* section, Misstatement of Age or Sex and 30 Day Right to Examine Certificate provisions are replaced by the following:

Misstatement of Age or Sex

If the Covered Person's age or sex has been misstated, We will adjust all benefits to the amounts that would have been purchased for the correct age or sex. The benefits payable under this Policy will be reduced under the Payment of Claims provision of the Policy.

10 Day Right To Examine Certificate

If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 10 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Oregon residents:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

South Carolina residents:

- 1) Under the *Claim Provisions* section, make the following changes:

Autopsy may be performed at the Insurer's expense, in the state of South Carolina. Revise Physical Examination and Autopsy provision as shown below:

Physical Examination and Autopsy

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending, and to have an autopsy performed at Our expense, in case of death where it is not forbidden by law. The autopsy must be performed in South Carolina.

Modify the number of years in which legal action may be brought from three years to six years, in the Legal Action provision as shown below:

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought at all unless brought within six years after the time such written proof of loss is required to be furnished.

- 2) Under the *General Provisions* section, the following changes are made:
a. The Entire Contract; Changes provision is replaced with the following:

Entire Contract; Changes

This Policy, including the endorsements, amendments, group applications and any attached papers constitutes the entire contract of coverage. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

- b. The Policy Termination provision is amended to include the following as last paragraph:

However, if the premium is to be collected in weekly, monthly, or other periodic installments by authority of a payroll deduction order executed by the Employee and delivered to Us or the Employer authorizing the deduction of premium installments from the Employee's salary or wages, We may not, during the period for which the Policy is issued and while the Employee remains employed by the authorized Employer, declare forfeited or lapsed the Policy until and unless a written or printed notice of the failure of the Employer to remit the premium or installment thereof, stating the amount or portion thereof due on the Policy and to whom it must be paid, has been duly addressed and mailed to the Employee who is insured under the Policy at least fifteen days before the Policy is terminated or lapsed.

South Dakota residents:

Under the *Exclusions* section, the following changes are made:

- a. Remove exclusions 5 and 6. South Dakota does not allow alcoholism and drug exclusions

- b. Modify exclusion 10, as shown below:
 - 10. services or treatment rendered by a Physician, Nurse or any other person who is:
 - a. employed or retained by Subscriber;
 - b. providing homeopathic, aroma-therapeutic or herbal therapeutic services.

Treatment by family members does apply in those areas in which the family member is the only Physician in the area and is acting within their scope of practice.

Texas residents:

1) Under the *Claim Provisions* section, make the following changes:

- a. The *Claim Forms, Proof of Loss* and *Time of Payment of Claims* provisions are replaced with the following:

Claim Forms

We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 16 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office within the first anniversary of the date the proof of loss is otherwise required. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than 60 days upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

If payment is delayed beyond the time period after receiving satisfactory proof of loss, We will be liable to pay the insured or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

Vermont residents:

- 1) Under the Policy and Certificate Face pages, the following disclaimer is added in capital letters:

THIS POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.

- 2) Under the *Schedule of Benefits* section, the following changes are made:

- a) Portability provision has been removed from this schedule and has been replaced with the Continuation for Loss of Eligibility.

The following Continuation for Loss of Eligibility benefit periods have been added:

Loss of Eligibility

Maximum Benefit Period

Employee to age 100

Spouse to age 100

Dependent Children to age 26

- 3) Under the *General Definitions* section, the following changes are made:

- a) **Dependent Child**

To the extent the policy provides insurance to dependent children, identical consideration must be applied to the children of same sex marriage partners or civil union partners:

Modify the definition of Dependent Child as follows:

Dependent Child An Employee's child who meets the following requirements:

1. A child from live birth to 26 years old.
2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap.

A child, for purposes of this provision, includes an Employee's:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of the Employee's Spouse or Domestic Partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;
3. stepchild who resides with the Employee and is financially dependent upon the Employee;
4. child for whom the Employee is the court-appointed legal guardian and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns;
5. a child of the Employee's Domestic Partner/Partner to a Civil Union, provided the child is living with, and is financially dependent upon the Employee.

Hospital

Add Vermont to item 1 in the first paragraph as shown:

1. It is licensed as a Hospital pursuant to applicable Vermont law;

Remove items 2 and 3 from the last paragraph as shown:

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care.

Injury

Replace the definition of Injury as shown:

Accidental bodily injury sustained by the insured person and directly caused by an accident which is not the result of disease or bodily infirmity,

- 4) Under the *Eligibility* provision section, the following changes are made:

- a) Add the following as the second paragraph:

An Employer shall not exclude part-time Employees and shall offer the same group health benefits to part-time Employees as it offers to the Employee groups of which the part-time Employees would be members if they were full-time Employees. The Employer shall offer to include the part-time Employees as part of the Employer's Employee group, at the full rate to be paid by the Employer and the Employee, at a rate prorated between the Employer and the Employee or at the Employee's expense. Part-time means any Employee who works a minimum of at least 17½ hours per week.

- b) Add the following two paragraphs under Spouse and Dependent Children:

Newborn Child(ren)

Coverage for a newly born child shall be provided without notice or additional premium for no less than 60 days after the date of birth.

Adopted Child(ren)

Coverage for a child under 18 due to adoption or placement of adoption for adoption of the child shall be provided as of the date of the adoption or placement for adoption. Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates the "placement of adoption" legal obligations.

- 5) Under the *Termination of Insurance/Continuation of Insurance Provisions*, the following changes are made:

- a) Add the following to the Termination of Insurance provision:

For Continuation for Loss of Eligibility, the coverage on a Covered Person will end of the earliest date below due to a Qualifying Event:

at any time after 12 months if the Covered Person is considered to reside outside of the United States. The Covered Person will be considered to reside outside the United States when the Covered Person has been outside the United States for a total period of 12 months or more during any 12 consecutive months.

b) Add the following provision to the *Continuation of Insurance* provision:

If an Employee is no longer in Active Service, coverage may be continued. The following provisions explain the continuation options available under this Policy. Please see the *Schedule of Benefits*, to determine the applicability of these benefits on a class level. Premiums are required for this coverage and are to be remitted in accordance with the *Payment of Premium* provision.

Continuation for Loss of Eligibility

If an Employee's coverage ends due to Loss of Eligibility from a qualifying event as defined in this section, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. The qualifying event means:

1. loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage;
2. divorce, dissolution, or legal separation of the covered employee from the employee's spouse or civil union partner;
3. a dependent child ceasing to qualify as a dependent child under the generally applicable requirements of the policy; or
4. death of the covered employee or member.

The Provisions of this section will not apply if

1. the deceased person or Employee was not insured under the group policy on the date of the qualifying event;
2. the person is covered by Medicare;
3. the person is covered by any other group insured or uninsured arrangement which provides dental coverage or hospital and medical coverage for individuals in a group and under which the person was not covered immediately prior to such qualifying event, and no preexisting condition exclusion applies.

6) Remove *Portability Provisions* section entirely.

7) Under the *Exclusions and Limitations* section, remove the following exclusion:

5. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction a Physician and taken in accordance with the prescribed dosage;

8) Under the *General Provisions* section, the following change is made:


Incontestability

Modify the following sentences as shown below:

After three years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

After three years from the Covered Person's effective date of coverage, or from the effective date of increased benefits, no such statement will cause coverage or the increased benefits to be contested except for fraud.

Signed for the
Life Insurance Company of North America



William J. Smith, President

GHIP-00-3000.00

**SUPPLEMENTAL INFORMATION
for**

University of Richmond (“Plan”)

**required by the Employee Retirement
Income Security Act of 1974**

As a Plan participant in University of Richmond's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in your Certificate are provided under a group insurance Policy issued by the Insurance Company. The Policy is incorporated into the Plan. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by University of Richmond, the Plan Sponsor.
- The Employer Identification Number (EIN) is 54-0505965.
- The Plan Number is 505.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, HC960598 (“Policy”), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA (“Insurance Company”).
- The Plan Administrator is:
University of Richmond
231 Richmond Way
UNIV. of Richmond, VA 23173
804-289-8167

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

The Plan Administrator designates and names the Insurance Company the named fiduciary for deciding claims and appeals for benefits under the Plan. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by applicable law.

Claims for Disability Benefits (applies to all claims filed on or after April 1, 2018)

A disability “claim” is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is “filed” as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company’s intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant’s name and address, and the group Policy holder’s name and address. Properly filed claims will be decided with independence and impartiality.

The Insurance Company has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Insurance Company must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company’s decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant’s response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician’s name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the claimant’s adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request;

8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Insurance Company for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Insurance Company issues an adverse benefit decision on appeal, if the Insurance Company considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Insurance Company intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;

6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Claims for Non-Disability Benefits (applies to all claims filed on or after April 1, 2018)

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

The Insurance Company has 90 days from the date the claim is filed to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90 day period. If this should happen, the Insurance Company will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary; and
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

Appeal of Denied Non-Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, the Insurance Company will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
5. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

ER-03-2

**UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a Cigna company**

Class 2

12/2019

