BlueCross BlueShield of Oklahoma

Voluntary Hospital Indemnity Insurance

Employee Benefit Booklet

CITY OF TULSA

F024608-0001

Class Low Plan

10/16/2024

Dearborn Life Insurance Company

(A stock life insurance company, herein called "*We*" "*Us*" or "*Our*")

Chicago, Illinois

Administrative Office Address: 701 E. 22nd Street, Lombard IL 60148

Having issued Group Policy No. F024608

(herein called the *Policy*)

to

CITY OF TULSA
(herein called the *Policyholder*)

GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE

CERTIFIES that *You* are insured, if *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, and remain insured in accordance with the terms of the *Policy*. *Your* insurance is subject to all the definitions, limitations and conditions of the *Policy*, and it takes effect as stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This *Certificate* describes *Your* eligibility for benefits and the terms and provisions of the *Policy*. It replaces and cancels any other *Certificate* previously issued to *You* under the *Policy*.

If the terms and provisions of this Group Insurance *Certificate* (issued to *You*) are different from the *Policy* (issued to the *Policyholder*), the issued Oklahoma Certificate will govern Oklahoma residents. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the *Policy*.

READ THIS CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

Secretary

President

Voluntary Group Hospital Indemnity Insurance Certificate
with Dependent Benefits
Non-Participating

THIS IS A LIMITED BENEFIT CERTIFICATE. IT PROVIDES HOSPITAL INDEMNITY INSURANCE COVERAGE. THERE IS NO COVERAGE FOR HOSPITAL, MEDICAL-SURGICAL OR MAJOR MEDICAL EXPENSES.

THIS TYPE OF PLAN IS NOT CONSIDERED "MINIMUM ESSENTIAL COVERAGE" UNDER THE AFFORDABLE CARE ACT 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 TAX PENALTY. PLEASE CONSULT YOUR TAX ADVISOR.

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

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SCHEDULE OF BENEFITS

POLICYHOLDER:	CITY OF TULSA
POLICY NUMBER:	F024608
POLICY EFFECTIVE DATE:	01/01/2025
ANNUAL ENROLLMENT PERIOD:	October 1 - October 31

ELIGIBILITY:
Class 01

All active full-time Employees, excluding Police and Fire enrolled in the Low Plan of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Eligibility Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 30 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.

Eligibility Waiting Period:

Current *Employees*: First of the month following 30 Days of continuous, full-time Active Work

New *Employees*: First of the month following 30 Days of continuous, full-time Active Work

Policyholder Contribution:

Voluntary Hospital Indemnity 0% of premium

HOSPITAL INDEMNITY:

Coverage For:

Employee, Spouse, and Dependent Child

Dependent Child benefits from live birth to age 26

Reduction of Benefits:

Benefits terminate at retirement.

Portability:

Benefit Eligibility	*Voluntary*
Insured Eligibility	*Employee, Spouse, Dependent Child(ren)*
Portability Benefit Duration	To Age 65

HOSPITAL INDEMNITY BENEFITS

Hospital Admission	$500 Payable once per calendar year
Hospital Intensive Care Unit (ICU) Admission	$1000 Payable once per calendar year
Hospital Confinement	$100 per day Up to 90 days per calendar year
Hospital Intensive Care Unit (ICU) Confinement	$200 per day Up to 30 days per calendar year
Rehabilitation Unit Confinement	$100 per day Up to 30 days per calendar year
Lodging Benefit	$100 per day Up to 30 days per calendar year
Wellness Benefit	$50 per day once per calendar year per *Covered Person*

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

The eligibility for this insurance is as indicated in the Schedule of Benefits.

The *Eligibility Waiting Period* is further defined in the Schedule of Benefits.

When does Your Contributory insurance become effective?

You may enroll for coverage during the *Annual Enrollment Period*, unless *You* qualify because of a *Change in Family Status*. *Your* coverage will become effective as indicated below, if *You* are *Actively at Work* on that date:

1. If *You* enroll for coverage prior to the *Policy Effective Date*, the *Policy Effective Date*;
2. If *You* enroll for coverage within 31 days of *Your* eligibility date, on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*;
3. If *You* enroll within 31 days of a *Change in Family Status*, on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*.
4. If *You* enroll during an *Annual Enrollment Period*, the next *Anniversary Date* following the *Annual Enrollment Period*.

Enrollment Form means the application *You* complete and submit to apply for coverage under the *Policy.*

Change in Family Status

If *You* experience a *Change in Family Status, You* may enroll for coverage, apply for additional coverage, or request changes to *Your* current insurance coverage, provided the change is consistent with the *Change in Family Status.* For *Your* coverage to become effective, *We* must receive a completed *Enrollment Form* within 31 days of the *Change in Family Status*.

Change in Family Status means:

1. *You* get married; or
2. *You* have a *Dependent Child*, or *You* adopt or become the legal guardian of a *Dependent Child*; or
3. *Your Spouse* dies or *You* become divorced; or
4. *Your Dependent Child* becomes emancipated or dies; or
5. *Your Spouse* is no longer employed, resulting in a loss of group insurance; or
6. *You* have a change in employment classification which results in *You* changing from part-time to full-time, or full-time to part-time employment.

When does Dependent Hospital Indemnity Insurance become effective?

If *You:*
1. have completed any required *Employee Eligibility Waiting Period*; and
2. apply for *Dependent Hospital Indemnity Insurance* no later than 31 days after becoming eligible for this benefit; and
3. have paid any applicable premium.

Hospital Indemnity Insurance for *Your Eligible Dependent(s)* will become effective on the later of:
1. the first of the month that falls on or next follows the date *Your* group insurance coverage becomes effective;
2. the first of the month that falls on or next follows the effective date of the *Dependent Hospital Indemnity Insurance* benefit; or
3. the first of the month that falls on or next follows the date *You* enroll *Your Eligible Dependent(s).*

If *You* enroll for *Dependent Hospital Indemnity Insurance* more than 31 days after *You* are eligible to do so, *You* must wait until the next *Annual Enrollment* period to apply for *Dependent* coverage.

Note: No eligible person may be covered more than once under the *Policy.* If a person is covered as an *Employee*, he cannot be covered as a *Spouse* or *Dependent Child* of another *Employee*. If both parents are covered as insured *Employees* under the *Policy,* only one may enroll for coverage on *Eligible Dependent* child(ren).

When does coverage for a new Spouse become effective?

Coverage for a new *Spouse* is effective on the date of *Your* marriage. *Your* new *Spouse* will be a *Covered Person* for 31 days. *Your Spouse* will cease to be a *Covered Person* unless:

1. *You* request, in writing within those 31 days continuation of such *Dependent* coverage; and
2. The required premium is paid. Premium will be charged from the date of marriage.

When does coverage for a newborn Child become effective?

If *You* have not previously elected *Dependent Child* coverage, coverage for a newborn *Child* starts automatically from the moment of birth if a *Child* is born to *You.* The newborn *Child* will be a *Covered Person* for 31 days. The newborn *Child* will cease to be a *Covered Person* after 31 days, unless:

1. *You* request in writing within those 31 days continuation of such *Dependent Child* coverage; and
2. The required premium is paid. Premium will be charged from the date of birth.

If *You* currently have *Dependent Child* coverage, *Your* newborn *Child* will be automatically added to *Your* coverage.

Dependent Child coverage will also be extended to newly adopted, foster or step *Children* and *Children* for whom *You* have been named legal guardian, as of the date they become financially dependent on *You* for support, provided they otherwise meet the definition of a *Dependent Child*.

Will the Effective Date of coverage be delayed if Your Dependent is confined to a Hospital?

The *Effective Date* of coverage will be delayed if *Your Dependent*, other than a newborn *Child*, is confined in a *Hospital* on the date coverage would otherwise become effective. In such case, the *Dependent's* coverage will become effective on the first day of the month that follows discharge from the *Hospital*.

What is an Enrollment Period?

Unless otherwise specified, ***Enrollment Period*** means a period of time during which *Eligible Employees* may apply for or request changes to coverage. The *Enrollment Period* is shown on the Schedule of Benefits.

Eligible Employees may enroll for coverage, apply for additional coverage, or request changes to their current coverage only during the *Enrollment Period,* unless they qualify because of a *Change in Family Status.*

Any *Employee* hired after an *Enrollment Period* may enroll within 31 days after his eligibility date; otherwise, he must wait for the next *Enrollment Period* to enroll unless he qualifies because of a *Change in Family Status*.

Initial requests for coverage or requests for changes to existing coverage made during the *Enrollment Period* will become effective on the anniversary date.

If You are not Actively at Work, when does coverage become effective?

If *You* are absent from *Active Work* on the date *Your* coverage would otherwise become effective and *Your* absence is caused by an *Injury*, *Illness* or layoff, *Your* effective date for any initial coverage or increased coverage will be deferred until the date *You* return to *Active Work.*

However, *You* will be considered *Actively at Work* on any day that is not *Your* regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if *You* were *Actively at Work* on the immediately preceding scheduled work day and *You* were:

1. not *Hospital Confined*; or
2. disabled due to an *Injury* or *Illness*.

What happens if We are replacing a Prior Policy?

Effect on Actively at Work requirement-Continuity of Coverage

If *You* were insured under the *Prior Policy* on the day before the *Policy* effective date, coverage begins for this *Policy* on the *Policy* effective date and continues until the earliest of:

1. The end of the month following the date *You* become *Actively at Work*;
2. The end of any period of continuance or extension provided under the *Prior Policy*; or
3. The date coverage would otherwise end, according to the provisions of this *Policy*.

Your coverage under this provision is subject to payment of premium.

The ***Prior Policy*** is the group hospital indemnity illness policy issued to the *Policyholder* whose coverage terminated immediately before the *Policy* effective date.

Effect on Benefits for Confinement in Progress on the Effective Date of this coverage?

If a *Covered Person* was insured and receiving benefits under the *Prior Policy* on the day before the effective date of this *Policy* and remains *Confined* on the effective date of this *Policy, We* will not pay the *Confinement* benefit for the continuing period of *Confinement.*

The ***Prior Policy*** is the group hospital indemnity illness policy issued to the *Policyholder* whose coverage terminated immediately before the *Policy* effective date.

Changes to Your coverage

A change in *Your* coverage may occur if:
1. *You* enroll for a different coverage option; or
2. There is a *Policy* change; or
3. *You* enter another class and become eligible for a change in benefits; or
4. *You* experience a qualified *Change in Family Status*.

If *You* are eligible for increased coverage due to a *Policy* change, the increased coverage will be effective on the date the *Policy* change is effective, as requested by the *Policyholder* and agreed on by *Us.*

Increases in coverage for reasons other than a *Policy* change will be effective the first of the month following the later of:
1. The date *You* enroll for the increased coverage; or
2. The date *You* become eligible for the increased coverage, if enrollment is not required.

In order for *Your* increased coverage to begin, *You* must be *Actively at Work*. Increased *Contributory* coverage is subject to *Our* receipt of premium.

A decrease in coverage will take effect immediately.

Increases or decreases to *Your* benefits elected during the *Enrollment Period* will become effective on the next anniversary date, if *You* are *Actively at Work* on that day.

Eligibility after You Terminate Employment

If *Your* coverage ends due to termination of employment and *You* do not elect continued coverage under the Portability Benefit provision, *You* must meet all the requirements of a new *Employee* if *You* are rehired by the *Policyholder* at a later date.

Exception: If *Your* coverage ends due to termination of employment and *You* return to *Active Work* for the *Policyholder* in an eligible class within 30 days, *We* will not apply a new *Eligibility Waiting Period*.

PORTABILITY BENEFIT

What is the Portability Benefit?

If *Your Voluntary* group *Hospital Indemnity Insurance* terminates, *You* may elect to continue *Your Hospital Indemnity Insurance* in accordance with the terms of the *Policy* by paying premiums directly to *Us*. If *You* elect Portability, *You* may also elect to continue *Dependent Hospital Indemnity Insurance* under the conditions set forth below, but *You* may not apply for *Dependent Hospital Indemnity Insurance* at the time *You* apply for Portability. The coverages eligible for Portability and the Portability Benefit Duration are in the Schedule of Benefits.

The premiums for the coverage continued under the Portability Benefit will not be the same as the premium *You* are charged for *Your* group *Hospital Indemnity Insurance* under the *Policy*. Portability premium will be based on:

1. *Our* current rates for the applicant's age and class of risk; and
2. the amount of insurance continued under Portability.

The maximum amount of *Hospital Indemnity Insurance* which may be continued under Portability is the amount of *Hospital Indemnity Insurance* in force at the time the Portability Benefit is elected.

What are Eligibility Requirements for Employee Portability?

To be eligible for Portability, *You* must meet the following conditions:

1. *You* must have been insured under the *Policy* or the *Policy* it replaced for at least one year prior to electing Portability; and
2. *Your Hospital Indemnity Insurance* must have terminated for reasons other than *Illness, Injury*, retirement or termination of the *Policy*; and
3. *You* must be less than 60 years of age.

You must submit a Request for Portability form and the first premium within 31 days after the date *Your Hospital Indemnity Insurance* terminated.

We reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* misrepresented any of the information provided to support eligibility for Portability.

Can Dependent Hospital Indemnity Insurance be Ported if Your Eligibility Terminates or if Your Spouse's Coverage Terminates?

Yes, *You* or *Your* insured *Spouse* may elect Portability of *Dependents' Hospital Indemnity Insurance* if *Dependents'* insurance coverage ceases as follows:

1. *You* may apply for Portability of *Dependent Hospital Indemnity Insurance* if *You* meet the eligibility requirements to port *Your Hospital Indemnity Insurance* as shown above and *You* are covered for *Dependent Hospital Indemnity Insurance* on the date *Your* coverage ceases.
2. *Your* insured *Spouse* may apply for Portability of his group *Hospital Indemnity Insurance*, on covered *Dependent Child(ren)* if:
    a. *Your Spouse'*s *Hospital Indemnity Insurance* terminates because *You* die or *Your* eligibility for *Dependent Hospital Indemnity Insurance* ceases for reasons other than retirement or termination of the *Policy* and *Your Spouse* is less than 60 years of age.
    b. *Your Spouse* had elected *Dependent Hospital Indemnity Insurance* on *Eligible Dependent Child(ren)* and such coverage is still in force when *Your* eligibility for *Dependent Hospital Indemnity Insurance* ceased for reasons other than retirement or termination of the *Policy*.
    c. *Your Spouse* must have been insured for such coverage(s) under the *Policy* for at least one year prior to electing Portability.
    d. Portability is not available if *Your Spouse's Hospital Indemnity Insurance* terminates because *Your Spouse* no longer meets the *Policy* definition of a *Eligible Dependent Spouse*.

If these criteria are met, *You* or *Your Spouse*, must submit a Request for Portability Form and pay the first premium within 31 days after the date such *Dependent Hospital Indemnity Insurance* terminated.

We reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* or *Your Spouse* misrepresented any information provided to support eligibility for Portability of *Dependent Hospital Indemnity Insurance*.

A Request for Portability Form means the form *You* complete and submit to apply for coverage under the Portability Benefit.

When will Portable Coverage Terminate?

Insurance continued under the Portability Benefit provision of the *Policy* will terminate at the earliest of the following:

1. the date *You* return to *Active Work* with the *Policyholder* while the *Policy* is still in force; or
2. the date required premiums are not paid when due; or
3. the end of the Portability Benefit Duration in the Schedule of Benefits; or
4. the premium due date following the date a *Dependent* ceases to meet the definition of an *Eligible Dependent*.

HOSPITAL INDEMNITY INSURANCE BENEFITS

What is the Hospital Admission Benefit?

The *Hospital Admission Benefit* is payable if a *Covered Person* is admitted for a *Hospital Confinement* of at least 20 hours for treatment of an *Injury* due to a covered *Accident* or treatment of an *Illness.* If *Hospital Confinement* is due to an *Injury* resulting from a covered *Accident*, the *Hospital Confinement* must start within 180 days of the *Accident.*

This benefit is payable only once per calendar year.

The benefit amount is listed in the Schedule of Benefits.

What is the Intensive Care Unit Admission Benefit?

The *Intensive Care Unit Admission Benefit* is payable if a *Covered Person*, upon initial admission for a *Hospital Confinement* of at least 20 hours for treatment of an *Injury* due to a covered *Accident* or treatment of an *Illness* is admitted to an *Intensive Care Unit*. If *Hospital Confinement* is due to an *Injury* resulting from a covered *Accident*, the *Hospital Confinement* must start within 180 days of the *Accident*.

This benefit will be paid in addition to the *Hospital Admission Benefit*.

This benefit is payable only once per calendar year.

The benefit amount is listed in the Schedule of Benefits.

What is the Hospital Confinement Benefit?

The *Hospital Confinement Benefit* is payable if a *Covered Person* is admitted for a *Hospital Confinement* of at least 20 hours for treatment of an *Injury* due to a covered *Accident* or treatment for an *Illness*. *Hospital Confinements* for treatment of an *Injury* due to a covered *Accident* must start within 180 days of the *Accident*.

This benefit will be paid in addition to any *Hospital Admission* and *Hospital Intensive Care Unit Admission* benefit due.

The benefit amount is listed in the Schedule of Benefits.

What is the Intensive Care Unit (ICU) Confinement Benefit?

The *Intensive Care Unit Confinement Benefit* is payable if a *Covered Person* is confined to an *Intensive Care Unit* for treatment of an *Injury* due to a covered *Accident* or treatment for an *Illness*. *ICU* confinement for treatment of an *Injury* due to a covered *Accident* must start within 180 days of the *Accident*.

This benefit will be paid in addition to any *Hospital Admission*, *Intensive Care Unit Admission* and *Hospital Confinement Benefit* due.

The benefit amount is listed in the Schedule of Benefits.

What is the Rehabilitation Unit Confinement Benefit?

The *Rehabilitation Unit Confinement Benefit* is payable when a *Covered Person* is *Confined* in a *Rehabilitation Unit* for treatment of an *Injury* due to a covered *Accident.* If a *Covered Person* is discharged from a *Rehabilitation Unit* and subsequently readmitted to a *Rehabilitation Unit* for treatment of the same *Injuries*, we will not pay an additional *Rehabilitation Unit Confinement Benefit*.

The *Rehabilitation Unit Confinement Benefit* will not be payable for the same days the *Hospital Confinement Benefit* is paid. The highest eligible benefit will be paid.

The benefit amount is listed in the Schedule of Benefits.

What is the Lodging Benefit?

The *Lodging Benefit* is payable if a companion accompanies a *Covered Person* who is admitted for a *Hospital Confinement* for the treatment of an *Injury* sustained in a covered *Accident* or *Illness* and requires and purchases overnight lodging. This benefit

is payable only for the same period of time the *Covered Person* is confined to the *Hospital.* The *Hospital* and lodge motel/hotel must be more than 100 miles from the residence of the *Covered Person*. This benefit is limited to one lodge room per night. The companion must incur an expense for the lodging.

For the purposes of this benefit, *Lodging* means an establishment licensed under the laws where it is located, such as a motel, hotel or other facility that provides sleeping accommodations to the general public in exchange for a fee.

The benefit amount is listed in the Schedule of Benefits.

WELLNESS BENEFIT

What is the Wellness Benefit?

If, while insured under the *Policy*, a *Covered Person* undergoes any of the *Wellness Tests* indicated below, *We* will pay the amount as set forth in the Schedule of Benefits.

Wellness Tests include:

- Blood test for triglycerides;
- Bone marrow aspiration or biopsy;
- CA 15-3 (blood test for breast cancer);
- CA-125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Carotid Doppler;
- Chest x-ray;
- Colonoscopy;
- COVID-19 test;
- Echocardiogram;
- Electrocardiogram;
- Fasting blood glucose test;
- Fasting plasma glucose (FPG);
- Flexible sigmoidoscopy;
- Hemoglobin A1C (HbA1c);
- Hemocult stool analysis;
- Mammography;
- Pap smear;
- PSA (blood test for prostate cancer);
- Serum cholesterol test to determine HDL and LDL levels;
- Serum protein electrophoresis (blood test for myeloma);
- Skin cancer biopsy;
- Stress test on a bicycle or treadmill;
- Thermography;
- Thin prep pap test;
- Two hour post-load plasma glucose;
- Vaccinations; or
- Virtual colonoscopy.

The *Wellness Benefit* is payable once per *Calendar Year* for each *Covered Person* .

Calendar Year means the period beginning January 1st and ending December 31st.

The *Wellness Tests* must be performed while the *Covered Person's* coverage under the *Policy* is in force. *Proof* must be provided that the test was performed.

LIMITATIONS AND EXCLUSIONS

Are there any Limitations and Exclusions for Hospital Indemnity Insurance?

In additions to the limitations and exclusions listed in the individual benefits, *We* will not pay any benefit for an *Injury* sustained in a covered *Accident* or *Illness* resulting from or caused by:

1. cosmetic surgery or other elective procedure that is not medically necessary; or
2. suicide or attempted suicide, while sane or insane; or
3. any intentionally self-inflicted *Injury*; or
4. combat training or war, declared or undeclared, while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; or
5. travel or flight in any aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
6. commission of, participation in, or an attempt to commit an assault or felony as defined by state or federal law; or
7. a loss that occurs while a *Covered Person* is legally incarcerated in a penal or correctional institution; or
8. active participation in a *Riot*. ***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder; or
9. driving or riding in any vehicle used in a race, speed or endurance test or for acrobatic or stunt driving; or
10. any *Admission* or *Confinement* of a newborn *Child* immediately following *Childbirth* unless the newborn is *Injured* or is born with an *Illness*.

Exclusions:

We will not pay any benefits for an *Accident* that occurred while the *Covered Person* was operating a motor vehicle and was either:

1. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a *Physician* and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
2. intoxicated as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if such jurisdiction does not define intoxication. Conviction is not necessary for a determination of being intoxicated.

TERMINATION PROVISIONS

When does Your coverage under the Policy end?

Unless *Hospital Indemnity Insurance* is continued under the Portability Benefit, *Your* coverage terminates on the earliest of the following dates:

1. the date on which the *Policy* is terminated; or
2. the date *You* stop making any required contribution toward payment of premiums; or
3. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
4. the date *You*:
    a. die; or
    b. are no longer a member of a class eligible for this insurance; or
    c. request termination of coverage under the *Policy;* or
    d. the date *You* retire; or
    e. the date *You* are no longer *Actively at Work* as a result of a *Disability*, layoff, leave of absence, military leave or labor dispute.

Termination will not affect *Your* claim for a covered *Loss* which occurred while the coverage was in force.

You may continue to be eligible for coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the disability began, if all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, if all premiums are paid when due.
Leave of Absence	Until the end of the twelfth month following the month in which the leave began, if all premiums are paid when due, as governed by the *Policyholder's* Human Resource policy on family and medical leaves of absence or in accordance with the FMLA provision below.
Military Leave	Until the end of the twelfth month following the month in which the military leave began, if all premiums are paid when due.
Labor Dispute	Until the end of the twenty-fourth month following the month in which the labor dispute began, provided all premiums are paid when due.

For the purposes of this provision, *Disability* means *You* are unable to perform all of the *Material* and *Substantial Duties* of *Your Regular Occupation.*

Will coverage be continued if You are eligible for leave under FMLA?

In the event *You* are eligible for and the *Policyholder* approves a leave of absence under the Family and Medical Leave Act of 1993 (FMLA), or any applicable state family and medical leave law (State FML), provided the required premium continues to be paid, *Your* insurance will continue for a period of up to the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state law.

You are eligible for leave under this Act in order to provide care:

1. After the birth of a *Child*; or
2. After the legal adoption of a *Child*; or
3. After the placement of a foster *Child* in *Your* home; or
4. To a *Spouse*, *Child* or parent due to their serious *Illness*; or
5. For *Your* serious health condition; or
6. For any event later added by amendment to the Act.

While granted a Family or Medical Leave of Absence:

1. The *Policyholder* must remit the premium required by the *Policy*; and

2. Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* leave of absence agreement with the *Policyholder*.

When does Dependent Hospital Indemnity Insurance coverage end?

Unless *Hospital Indemnity Insurance* is continued under the Portability Benefit provision, *Dependent Hospital Indemnity Insurance* coverage will end on the earliest of:

1. the date *You* are no longer *Actively at Work* except in the case of *Disability*, layoff, or leave of absence, or military leave as set forth above; or
2. the date on which the *Policy* is terminated; or
3. the date *You* stop making any required contribution toward payment of premiums; or
4. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
5. the date:
   a. *You* are no longer a *Member* of a class eligible for this insurance; or
   b. *You* request termination of coverage under the *Policy*; or
   c. *You* retire; or
6. the date a *Dependent Child* or *Spouse* no longer meets the Policy definition of *Eligible Dependent;* or
7. the date of *Your* death.

Coverage will continue past the age limit for *Eligible Dependent Children* who are primarily dependent on *You* for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Written proof of such incapacity must be provided to *Us* on request.

GENERAL PROVISIONS

Entire Contract; Changes

The *Policy*, the *Policyholder's Application*, the *Employee's* Certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the *Policy* can be amended by mutual consent between the *Policyholder* and *Us.* No change in the *Policy* is valid unless approved in writing by one of *Our* executive officers and unless such approval is endorsed hereon or attached hereto. No agent has the right to change the *Policy* or to waive any of its provisions.

Statements on the Application

In the absence of fraud, all statements made in any signed application are considered representations and not warranties (absolute guarantees). No representation by:

1. the *Policyholder* in applying for the *Policy* will make it void unless the representation is contained in his signed *Application*; or
2. any *Employee* in enrolling for insurance under the *Policy* will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the *Employee* is or has been given to the *Employee*.

Legal Actions

Unless otherwise provided by federal law, no legal action of any kind may be filed against *Us*:

1. until 60 days after proof of claim has been given; or
2. more than 3 years after *Proof* must be filed, unless the law in the state where *You* live allows a longer period of time.

Clerical Error

Clerical error or omission by *Us* to the *Policyholder* will not:

1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the *Policy*; or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about *You* that is incorrect, *We* will:

1. Use the facts to decide whether *You* have coverage under the *Policy* and in what amounts; and
2. Make a fair adjustment of the premium.

Time Limit on Certain Defenses

The validity of the *Policy* shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of the *Policy* shall not be contested on the basis of a statement made relating to insurability by any person covered under the *Policy* after such insurance has been in force for two years during such person's lifetime and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

Premium Provisions

Premiums are payable in United States dollars on or before their due dates. The *Policyholder* has agreed to deduct from *Your* pay any premiums payable for *Your Contributory* coverage. The *Policyholder* agrees to and is responsible for remitting such premiums for the entire time coverage under the *Policy* is in effect.

Premium charges for increases in insurance amounts becoming effective during a *Policy* month will begin on the next premium due date. Premium charges for insurance terminating during a *Policy* month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.

Misstatement of Age

If *You* have misstated *Your* age or the age of a *Dependent*, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

Conformity with State Statutes and Regulations

Any provision of the *Policy* which, on its effective date, conflicts with the statutes and regulations of the state in which the *Policy* was issued, it is automatically changed to meet the minimum requirements of such statutes.

Retention of Discretion

We shall have the exclusive right to interpret the terms of the *Policy*. The decision about whether to pay any claim, in whole or in part, is within *Our* discretion and such decisions shall be final and conclusive.

UNIFORM CLAIM PROVISIONS

Initial Notice of Claim

We must receive written notice of *Loss* within 30 days of the date of *Loss*, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to any authorized agent of *Ours*.

Claim Forms

Within 15 days of *Our* being notified in writing of a claim, *We* will supply the claimant with the necessary claim forms. The claim form is to be completed and signed by the claimant, the *Policyholder* and the claimant's *Physician.* If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written *Proof* of loss if *We* receive written *Proof*, which describes the occurrence, extent and nature of the loss.

Time Limit for Filing Your Claim

We must receive written *Proof* within 90 days after the date a *Loss* is incurred. If it is not possible to give *Us* written *Proof* within 90 days, the claim is not affected if the *Proof* is given as soon as possible. However, unless the claimant is legally incapacitated, written *Proof* of loss must be given no later than one year after the time *Proof* is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time *Proof* is due. However, benefits may be paid if it can be shown that:
1. It was not reasonably possible to give written *Proof* during the one year period, and
2. *Proof* satisfactory to *Us* was given as soon as was reasonably possible.

We will give *You* written response to *Your* claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, *We* notify *You* in writing that an extension is necessary due to matters beyond *Our* control, identify those matters and gives the date by which *We* expect to render a decision. If the extension is due to *Your* failure to submit information necessary to decide *Your* claim, the time for decision shall be tolled from the date on which *We* send *You* notice of the extension until the date *We* receive *Your* response to *Our* request. This period will be no longer than 45 days after *We* have requested the information. At that time *We* will decide *Your* claim based on the information *We* have at that time.

Time of Payment of Claim

Benefits for loss covered by the *Policy* will be paid immediately upon *Our* receipt of all due written *Proof* of loss.

Physical Examination/Autopsy

On receipt of a claim, *We* may have an *Insured* examined, at *Our* expense, at any reasonable time. *We* may have an autopsy performed, at *Our* expense, if it is not prohibited by any applicable local law(s).

Who will receive Your Hospital Indemnity Insurance Benefits?

Hospital Indemnity Insurance benefits are payable to *You* unless such benefits have been assigned. The *Policyholder* may not be named as beneficiary. In the event of *Your* death prior to *Hospital Indemnity Insurance* benefits being paid, benefits will be paid according to the Facility of Payment provision.

Facility of Payment

If no named beneficiary survives *You* or if *You* do not name a beneficiary, *We* will pay the amount of insurance:
1. to *Your Spouse*, if living; if not,
2. in equal shares to *Your* then living natural or legally adopted *Children*, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and/or sisters, if living; if not,
5. to *Your* estate.

Do I have the Right to Appeal a Claim Denial?

If *Your* claim is denied, in whole or in part, *You* will receive a written notice giving the following:

- the reason or reasons for the denial;
- the *Policy* provisions on which the denial is based;
- an explanation of what other material or information, if any, may be needed to process the claim and why it is needed;
- the steps that *You* have to follow to have the claim reviewed;
- a statement that *You* have the right to bring a civil action under section 502(a) of ERISA after *You* appeal *Our* decision and after *You* receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to *You* upon request; and
- if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to *Your* medical circumstances, or (ii) a statement that such explanation will be provided to *You* free of charge upon request.

If the claim has been denied, in whole or in part, *You* can appeal the denial to *Us* for a full and fair review. *You* have at least 180 days to appeal from the claim denial.

You may:

a. request a review upon written application within 180 days of the claim denial;
b. request, free of charge, copies of all documents, records and other information relevant to *Your* claim; and
c. submit written comments, documents, records and other information relating to *Your* claim, without regard to whether such information was submitted or considered in the initial benefit determination.

We will make a decision no more than 45 days after *We* receive *Your* appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, *We* notify *You* in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If *Your* claim is extended due to *Your* failure to submit information necessary to decide *Your* claim on appeal, the time for *Your* decision shall be tolled from the date on which the notification of the extension is sent to *You* until the date *We* receive *Your* response to the request.

The decision on appeal will provide the following:

- the reason or reasons for the decision;
- the Plan provision on which the decision is based;
- a statement that *You* are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to *Your* claim for benefits;
- a statement of the claimant's right to bring an action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision and that a copy will be provided free of charge to *You* upon request;
- if the decision is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to *Your* medical circumstances, or (ii) a statement that such explanation will be provided to *You* free of charge upon request; and
- the following statement: "*You* and *Your* plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact *Your* local U.S. Department of Labor Office and *Your* State insurance regulatory agency."

GENERAL DEFINITIONS

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable which occurs while the *Covered Person's* insurance is in effect.

Actively at Work or ***Active Work*** means that *You* must:
1. work for the *Policyholder* on a full-time active basis; or
2. work at least the minimum number of hours set forth in the Schedule of Benefits: and either:
   a. work at the *Policyholder*'s usual place of business; or
   b. work at a location to which the *Policyholder*'s business requires *You* to travel; and
3. not be a temporary or seasonal *Employee*; and.
4. be paid regular earnings by the *Policyholder*.

You will be considered *Actively at Work* if *You* were actually at work on the day immediately preceding:
1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); or
6. emergency leave of absence (except emergency medical leave); and
7. *You* were not *Hospital Confined* or disabled due to an *Injury* or *Illness*.

Anniversary Date means the annual month and day that corresponds with the *Policy Effective Date*.

Annual Enrollment Period means the annual timeframe defined in the Schedule of Benefits when *Employees* can make benefit changes.

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.

Certificate means this *Hospital Indemnity Insurance Certificate*.

Childbirth means the birth of a child by routine vaginal delivery or non-emergency cesarean section.

Child(ren) means:
1. *Your* natural or step *Child* under the age stated in the Schedule of Benefits; or
2. a *Child* under the age stated in the Schedule of Benefits placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the *Child*. Eligibility will continue unless the *Child* is removed from placement; or
3. a *Child* of *Your Child* who is *Your* dependent for federal income tax purposes at the time application for coverage of the *Child* of *Your Child* is made.

Complications of Pregnancy means an abnormal condition or concurrent diseases that significantly affect the pregnancy's usual medical management. A complication may exist during the pregnancy, during the birth or after the birth.

Contributory means *You* pay all or a portion of the premium for this insurance coverage.

Covered Person means an *Employee or Eligible Dependent* covered under the *Policy*.

Dependent means:
1. *Your* lawful *Spouse*; and/or
2. *Your Child*(ren) who are not in active military service; and are within the age limits set forth in the Schedule of Benefits.

Employee or Eligible Employee means an *Actively at Work,* full-time *Employee* working in the United States of America as shown in the Schedule of Benefits whose principal employment is with the *Policyholder* and who is reported on the *Policyholder*'s records for Social Security and withholding tax purposes.

Enrollment Form means a form acceptable to *Us* that *You* complete to enroll for coverage under the *Policy*.

Hospital means an institution that meets all of the following:

- is licensed as a *Hospital* pursuant to applicable law;
- is primarily and continuously engaged in providing medical care and treatment to ill and injured persons;
- it is managed under the supervision of a staff of *Physicians*;
- provides 24-hour nursing services by or under the supervision of a registered Nurse;
- has medical, diagnostic and treatment facilities with major surgical facilities on its premises, or available to it on a prearranged basis; and
- it charges for its services.

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

- rehabilitation, convalescent, custodial, educational, hospice or skilled nursing care;
- the aged;
- substance abuse, drug abuse or alcohol abuse;
- a facility primarily or solely providing psychiatric services for *Mental or Nervous Disorders.*

Hospital Confinement or Confinement means the assignment to a bed as an inpatient in a *Hospital* on the advice of a *Physician* for a period of no less than 20 continuous hours.

Illness means sickness, disease, pregnancy or complications of pregnancy.

Intensive Care Unit or ICU means a place which:

- is a specially designated area of the *Hospital* called an *Intensive Care Unit* that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; and
- is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient *Confinement;* and
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and
- is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the *Intensive Care Unit* on a 24-hour basis; and
- has a *Physician* assigned to the *Intensive Care Unit* on a full-time basis.

An *Intensive Care Unit* is not a progressive care unit, an intermediate care unit, a private monitored room, sub-acute *Intensive Care Unit*, an observation unit or any facility not meeting the definition of an *Intensive Care Unit* as defined above.

An *Intensive Care Unit* that meets the definition above includes *Hospital* units with the following names:

- *Intensive Care Unit*;
- Coronary Care Unit;
- Neonatal *Intensive Care Unit*;
- Pulmonary Care Unit;
- Burn Unit; or
- Transplant Unit.

Injury means bodily harm resulting directly from an *Accident* and independently of all other causes.

Insured means an *Employee* or *Dependent* covered under the *Policy*.

Male Pronoun whenever used includes the female.

Material and Substantial Duties means duties that are normally required for the performance of *Your Regular Occupation* which cannot be reasonably omitted or modified.

Physician means a person other than a *Covered Person*, a member of a *Covered Person's* immediate family or a *Covered Person's* business associate, who is licensed to and actively practicing medicine in the United States and is licensed to treat *Illness* and *Injury*.

Policy means the contract between the *Policyholder* and *Us* including the *Application*, this *Certificate* and any amendments, riders or endorsements.

Policy Effective Date or ***Effective Date*** means the date stated on the Schedule of Benefits.

Policyholder means the person, firm, or institution to whom the *Policy* was issued. *Policyholder* also means any covered subsidiaries or affiliates set forth on the face of the *Policy*. If the *Policyholder* is an association the term *Participating Employer* shall be substituted for *Policyholder*.

Pregnancy means the condition or period of being pregnant.

Proof means evidence satisfactory to *Us* that the *Covered Person* has an *Illness* or sustained an *Injury* for which a covered benefit listed in the Schedule of Benefits has been received. *Proof* includes any additional information *We* may request. *We* reserve the right to determine, at *Our* discretion, if *Proof* is acceptable under the terms of the *Policy*.

Regular Occupation means the occupation that *You* are routinely performing when *Your* insurance terminates due to *Disability*. *We* will look at *Your* occupation as it is normally performed in the national economy instead of how the work tasks are performed for *Your Policyholder* or at *Your* specific location.

Rehabilitation Unit means an appropriately licensed facility or unit of a *Hospital* that provides rehabilitation care on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational and vocational services to enable patients disabled by an *Injury* or *Illness* to achieve the highest possible functional ability. Services provided by or under the supervision of an organized staff of *Physicians*.

A *Rehabilitation Unit* is not:

- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a hospice care facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Spouse means lawful *Spouse*.

Voluntary means coverage for which *You* pay 100% of the premium.

We, ***Our*** and ***Us*** means Dearborn Life Insurance Company.

You, ***Your*** and ***Yours*** means the *Employee* to whom this *Certificate* is issued and whose insurance is in force under the terms of the *Policy*.

NOTICE OF
PROTECTION PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

"Health benefit plan" is defined in 36 O.S. §2024(7) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

END OF CERTIFICATE

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148