STANDARD INSURANCE COMPANY

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

GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE AND SUMMARY PLAN DESCRIPTION

Policyholder:	Trustees of the Cooperative Welfare Benefits Fund (Iowa and Nebraska)
Employer(s):	Trustees of the Cooperative Welfare Benefits Fund (Iowa and Nebraska) Any employer which participates in the Trustees of the Cooperative Welfare Benefits Fund (Iowa and Nebraska) and which has elected participation under the Group Policy and is approved by us.
Group Policy Number:	648216-F
Group Policy Effective Date:	01/01/2023
State Of Issue:	Iowa

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

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

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

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

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

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

STANDARD INSURANCE COMPANY

By

President and CEO

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INDEX OF DEFINED TERMS

COVERAGE FEATURES

Employer(s)

Trustees of the Cooperative Welfare Benefits Fund (Iowa and Nebraska)

Any employer which participates in the Trustees of the Cooperative Welfare Benefits Fund (Iowa and Nebraska) and which has elected participation under the Group Policy and is approved by us.

Member

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

- An active full time employee of the Employer.
- Regularly working at least 30 hours each week.
- A citizen or resident of the United States.

You are not a Member if you are:

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

Class(es)

All Members

Eligibility Waiting Period

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

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

Premium Contributions

For you and your Dependents:	Contributory
For your Spouse:	Contributory

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

Table Of Hospital Indemnity Insurance Amounts

All benefits are based on a per day schedule.

Hospitalization Benefits

Daily Critical Care Unit Confinement Benefit	$250 per day
Daily Hospital Confinement Benefit	$250 per day
Hospital Admission Benefit	$1,000 per day

Additional Benefits

Health Maintenance Screening Benefit	$50 per day

Additional Features

Reinstatement

Waiver of Premium

Continuation of Insurance (Portability) for the Member

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan:	Group Hospital Indemnity Insurance
Name, Address of Plan Sponsor:	Trustees of the Cooperative Welfare Benefits Fund (Iowa and Nebraska) 1415 28th Street, Suite 100 West Des Moines, IA 50266
Plan Sponsor Tax ID Number:	42-1294150
Plan Number:	502
Type of Plan:	Group Insurance Plan
Type of Administration:	Contract Administration
Name, Address, Phone Number of Plan Administrator:	Plan Sponsor 515-226-0303
Name, Address of Registered Agent for Service of Legal Process:	Trustees of the Cooperative Welfare Benefits Fund (Iowa and Nebraska)
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093
Sources of Contributions:	Member
Funding Medium:	Standard Insurance Company - Fully Insured
Plan Fiscal Year End:	December 31

ELIGIBILITY AND ENROLLMENT

Becoming Insured

To become insured you must:

- Be a Member.
- Complete your Eligibility Waiting Period.
- Meet the requirements shown in **When Your Insurance Becomes Effective** and **Active Work Requirement**.
- Submit Evidence Of Insurability, if required.

When Your Insurance Becomes Effective

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

Insurance Not Subject to Evidence Of Insurability

Contributory Insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance not subject to Evidence Of Insurability becomes effective on:

- The date you become eligible if you apply on or before that date.
- The date you apply if you apply within 31 days after you become eligible.
- The January 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply if you apply within 31 day(s) of the Family Status Change.
  - The January 1 next following the Annual Enrollment Period if you apply for the Family Status Change during the Annual Enrollment Period.

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

Family Status Change means any of the following events:

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

Changes in Your Insurance

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

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

Increases Not Subject to Evidence Of Insurability

Increases not subject to Evidence Of Insurability become effective on the latest of:

- The January 1 next following the Annual Enrollment Period during which you apply for the increase.
- The date of your Family Status Change.

Decreases in insurance amounts become effective on:

- The first day of the calendar month coinciding with or next following the date the Policyholder or Employer receives your written request for the decrease.

Active Work Requirement

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

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

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

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

When Your Insurance Ends

Insurance ends automatically on the earliest of the following:

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

CHILD INSURANCE

Eligibility for Child Insurance

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

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

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

When Child Insurance Becomes Effective

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

Child Insurance Not Subject to Evidence Of Insurability

Contributory Child insurance becomes effective on the latest of:

- The date your insurance becomes effective if you apply on or before that date to insure your Child.
- The date you apply to insure your Child.
- The January 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
    - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
    - The date you apply if you apply within 31 day(s) of the Family Status Change.
    - The January 1 next following the Annual Enrollment Period if you apply for the Family Status Change during the Annual Enrollment Period.

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

Changes in Child Insurance

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

Child Insurance Increases Not Subject to Evidence Of Insurability

Increases in your Child insurance not subject to Evidence Of Insurability become effective on the date of your insurance increases.

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

except for increases or plan changes during your Employer's Annual Enrollment Period.

When Child Insurance Ends

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

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

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

SPOUSE INSURANCE

Eligibility for Spouse Insurance

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

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

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

When Spouse Insurance Becomes Effective

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

Spouse Insurance Not Subject to Evidence Of Insurability

Contributory Spouse Insurance becomes effective on the later of:

- The date your insurance becomes effective if you apply on or before that date to insure your Spouse.
- The date you apply to insure your Spouse.
- The January 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply, if you apply within 31 day(s) of a Family Status Change.
  - The January 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.

Changes in Spouse Insurance

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

Subject to your Spouse being gainfully employed or capable of performing the material duties of an occupation, increases in your Spouse insurance become effective as follows:

Spouse Insurance Increases Not Subject to Evidence Of Insurability

Increases in your Spouse insurance not subject to Evidence Of Insurability become effective on the date of your insurance increases.

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

except for increases or plan changes during your Employer's Annual Enrollment Period.

When Spouse Insurance Ends

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

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

HOSPITAL INDEMNITY BENEFITS

Insuring Clause

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

Hospitalization Benefits

Daily Critical Care Unit Confinement Benefit

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

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

We will pay a Daily Critical Care Unit Confinement Benefit for up to 30 day(s) per Confinement per insured person.

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

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

Daily Hospital Confinement Benefit

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

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

We will pay a Daily Hospital Confinement Benefit for up to 30 day(s) per Confinement per insured person.

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

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

Hospital Admission Benefit

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

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

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

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

Additional Benefits

Health Maintenance Screening Benefit

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

- A Health Maintenance Screening Procedure is performed.

Health Maintenance Screening Procedures are limited to the following:

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

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

EXCLUSIONS AND LIMITATIONS

Exclusions

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

- War or act of War. War means declared or undeclared war, whether civil or international, insurrection, and any substantial armed conflict between organized forces of a military nature.
- Attempted suicide or other intentionally self-inflicted injury, while sane or insane.
- Committing or attempting to commit an assault, felony or act of terrorism, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing official duties.
- Alcoholism, drug abuse, misuse of alcohol or any other substance, the voluntary use or consumption of any drug or alcohol in excess of the legal limit in the state in which the Injury occurred, or taking of drugs unless used or consumed according to the directions of a Health Care Provider.
- Travel or flight in or on any aircraft, except:
    - As a fare-paying passenger on a regularly scheduled commercial flight.
    - As a passenger or pilot in the Policyholder's or Employer's aircraft while flying on the Policyholder's or Employer's business provided:
        - The aircraft has a valid U.S. airworthiness certificate (or foreign equivalent).
        - The pilot has a valid pilot's certificate with a non-student rating authorizing him or her to fly the aircraft.
- Dental care or dental procedures, unless treatment is the result of an Injury.
- Routine newborn nursing or well-baby care.
- Hospital Confinement of a newborn Child following the Child's birth unless the Confinement is as a result of an Injury or Sickness.
- Riding in or driving any automobile in a race, stunt show, or speed test.
- Surgery or other procedure which is directed at improving your or your Dependent's appearance, unless such surgery or procedure is necessary to correct a deformity or to restore bodily function resulting from an Injury or Sickness.
- Any Injury of Sickness which arises out of or in the course of your or your Dependent's incarceration in a jail, penal or correctional institution.

ADDITIONAL FEATURES

Reinstatement

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

- If your insurance ends because you cease to be a Member and if you become a Member again within 90 day(s) the Eligibility Waiting Period will be waived.
- If you ceased to be a Member under the Group Policy and continued insurance under the **Continuation of Insurance (Portability) for the Member** provision and you become a Member again within 90 day(s), your insurance will be for the coverage and amount which you continued

under the **Continuation of Insurance (Portability) for the Member** provision the day before you become a new Member.

In no event will insurance be retroactive.

Waiver of Premium

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

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

Continuation of Insurance (Portability) for the Member

Eligibility for the Member

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

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

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

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

Application, Amount of Insurance, and Premium Payment

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

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

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

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

When Insurance Ends

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

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

- The date you become insured again as a Member under the Group Policy.

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

CLAIMS AND BENEFIT PAYMENT

Filing a Claim

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

Time Limits on Filing Proof Of Loss

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

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

Proof Of Loss

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

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

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

Investigation of Claim

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

Notice of Decision on Claim

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

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

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

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- A description of any additional information needed to support the claim.
- Information concerning the claimant's right to a review of our decision.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

Review Procedure

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

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

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

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

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

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

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

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

Time of Payment

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

Payment of Benefits

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

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

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

Reimbursement

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

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

Unpaid Premium

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

GENERAL PROVISIONS

Assignment

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

Time Limits on Legal Actions

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

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

Incontestability of Insurance

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

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

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

Clerical Error

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

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

Agency

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

Misstatement of Age

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

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

DEFINITIONS

Admitted or Admission

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

Calendar Year

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

Child or Children

Child or Children means one of the following:

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

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

Confinement or Confined

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

Critical Care Unit (CCU)

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

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

Dependent(s)

Your Spouse or Child.

Eligibility Waiting Period

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

Employer

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

Evidence Of Insurability

You or your Dependent must:

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

Group Policy

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

Health Care Provider

A Physician, Nurse Practitioner, or Physician Assistant.

Hospital

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

Injury or Injuries

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

Inpatient

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

Loss

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

Mental Disorder

Any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, or anxiety and anxiety disorders. Mental Disorder does not include:

- Alcohol or drug dependency.
- Dementia as a result of stroke, trauma, viral infection, Alzheimer’s disease or other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Nurse Practitioner (advanced practice registered nurse)

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

Physician

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

Physician Assistant

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

Pregnancy

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

Prior Plan

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

Sickness

Your or your Dependent's sickness, illness, or disease. Sickness includes Pregnancy.

Spouse

Spouse means:

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

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

ERISA INFORMATION AND NOTICE OF RIGHTS

Grant of Discretion

Your Plan Sponsor has delegated to us the discretion to determine eligibility for benefits and to construe and interpret the terms and provisions of the Group Policy, subject to any and all remedies that may exist under State and Federal law.

Statement of Your Rights under ERISA

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Right to Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

Right to Obtain Copies of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

Right to Receive a Copy of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

Right to Review of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

Obligations of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all 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 Plan benefit or exercising your rights under ERISA.

Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 Plan 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.

Plan and ERISA Questions

If you have any questions about the 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 Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTICE OF PROTECTION PROVIDED BY

IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association Act (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, located at Iowa Code Chapter 508C, 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, health insurance company or health maintenance organization 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 Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance:

- $300,000 in death benefits
- $100,000 in net cash surrender and withdrawal values

Health Insurance:

- $500,000 for health benefit plans (see definition below)
- $300,000 in disability income protection insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits, including net cash surrender and withdrawal values

Annuities:

- $250,000 in the present value of annuity benefits, including net cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in the applicable Iowa law 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.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. 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 under Iowa law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term rider relates. To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's website at www.ialifega.org or contact:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut Street, Suite 1600
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
1963 Bell Ave, Suite 100
Des Moines, IA 50309-3738
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Ratings Inc., Moody's Investors Service, and S&P Global Ratings.

The Association is subject to the supervision of the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa 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 Iowa law, then Iowa law will control.