Globe Life And Accident Insurance Company, a Nebraska Stock Company

Administrative Office
C/O The Loomis Company
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PO Box 7011
Wyomissing, PA 19610-6011
Phone: 1-800-208-2066

Home Office: 3700 S Stonebridge Dr, McKinney, TX 75070

Group Limited Indemnity Policy

POLICYHOLDER NAME:	Wichita Falls Independent School District
POLICYHOLDER ADDRESS:	1104 Broad St Wichita Falls, TX 76301

POLICY NUMBER:	BZ0019	**POLICY EFFECTIVE DATE:**	September 1, 2024
DATE OF ISSUE:	September 1, 2024	**ANNIVERSARY DATE:**	September 1

This *Policy* is executed by Globe Life And Accident Insurance Company (herein called the *Company*). In consideration of the *Policyholder's* application and the timely payment of premiums, the *Company* agrees to pay the benefits of this *Policy*, subject to all of its terms and conditions.

This *Policy* is executed by the *Company* as of the Date of Issue. This *Policy* will take effect on the Policy Effective Date, shown above, at 12:01 a.m. Standard Time at the address of the *Policyholder*.

Secretary

President

THIS IS A LIMITED BENEFIT POLICY. It provides fixed-benefit payments. Benefits provided are not intended to cover all hospital or other medical expenses.

This Policy is a contract between the Policyholder and the Company. This *Policy* is subject to Texas. This *Policy* is renewable at the option of the *Company*. Please read the Termination of Insurance provision of this *Policy*. The *Company* may change rates, subject to the *Policy's* Premium Rate Changes provision. No such change in *Premium* will be made unless 60 days prior notice is given to the *Policyholder*.

READ THE POLICY CAREFULLY.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATION THAT MUST BE FILED AND POSTED.

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GENERAL POLICYHOLDER PROVISIONS

INCORPORATION PROVISION: The provisions of the attached *Certificate*(s), any rider(s), endorsement(s), or amendment(s) (including any rider(s), endorsement(s), or amendment(s) added after the Policy Effective Date), are made a part of this *Policy*. The *Certificate(s)*, rider(s), endorsement(s), and amendment(s) attached to this *Policy* will control each *Insured's* coverage, eligibility, effective date, termination date, benefits and exclusions.

ENTIRE CONTRACT-CHANGES: The entire contract shall include:
1. the *Policy*;
2. the application of the *Policyholder*;
3. the *Certificates*;
4. the *Insured's* enrollment form, if any; and
5. all riders, endorsements and amendments.

Unless fraudulent, all statements made by the *Policyholder* to obtain the *Policy* are considered representations and not warranties.

The terms of the *Policy* can be changed only by rider, endorsement or amendment signed by an executive officer of the *Company*. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the *Policyholder*. No agent may change the *Policy* or waive its provisions.

EXAMINATION OF THE POLICY: This *Policy* will be available for inspection at the *Policyholder's* office during regular business hours.

CERTIFICATES: A *Certificate* will be issued for delivery to the *Insured*. The *Certificate* will describe:
1. the benefits under this *Policy*;
2. to whom benefits will be paid; and
3. the limitations and terms of the *Policy*.

If there is a conflict between the *Policy* and the *Certificate*, the *Policy* will control.

INELIGIBLE EMPLOYEES: The *Policyholder* must notify the *Company* within 60 days of the date an *Insured* is no longer eligible for coverage.

LEGAL ACTION: No legal action may be brought to recover under this *Policy*:
1. within 60 days after written Proof of Loss has been furnished as required; or
2. more than 3 years from the time written Proof of Loss is required to be furnished.

INCONTESTABILITY:
After two years from the Policy Effective Date, no statements contained in a written instrument signed by the individual making the statements will be used to contest the validity of this *Policy* or to deny a *Claim* for loss incurred after the expiration of the two-year period, except in the case of fraud or material misrepresentation.

CLERICAL ERROR: A clerical error by the *Policyholder* will not end coverage or continue terminated coverage. In the event of such clerical error, a *Premium* adjustment will be made.

CONFORMITY WITH STATE LAWS: A provision of the *Policy* that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

NEW ENTRANTS: New *Employees* of the *Policyholder* and their *Dependents* will be added to the applicable class originally insured under this *Policy* provided they apply for such coverage and meet the requirements for eligibility as stated in the *Policy*.

WORKERS' COMPENSATION: The *Policy* is not a Workers' Compensation policy. The *Policy* does not satisfy any requirement for coverage by Workers' Compensation Insurance.

PREMIUM PROVISIONS

PREMIUMS
Premiums will be computed in accordance with the rates in effect on the *Premium* due date. The total *Premium* for the *Policy* is the sum of *Premiums* for all *Insureds*.

The first *Premium* is due on the Policy Effective Date. *Premiums* after the first are due at the end of the period for which the preceding *Premium* was paid.

PREMIUM PAYMENTS
The *Policyholder* is responsible for paying all *Premiums*. However, the *Premiums* may be paid by any other party according to a mutual agreement among the other party, the *Policyholder* and the *Company*.

Premiums may be paid to:
1. the *Company's* Administrative Office; or
2. the *Company's* authorized agent.

Payment of *Premium* for a period before it is due will not guarantee that the coverage will remain in effect for that period.

PREMIUM RATE CHANGES
The *Company* may change premium rates once the rate guarantee period listed in the Premium Rate Guarantee provision has elapsed following the Policy Effective Date, or on any *Premium* due date after that. Any subsequent rate changes will not be made more frequently than once every 12 months. No such change in *Premium* will be made unless 60 days prior notice is given to the *Policyholder*.

The rates may change prior to the time frames outlined above, however, for reasons that affect the *Insured* risk, which include:
1. a change in benefits;
2. a new law or change in any existing law that affects this *Policy*; or
3. a material change in the composition or size of the *Insureds* covered under this *Policy*.

PREMIUM RATE GUARANTEE
Premium rates may be guaranteed for a period of 1 year. During this time, no change may be made to the *Premium* unless one of the events listed in the Premium Rate Changes provision occurs.

GRACE PERIOD
A grace period of 31 days will be allowed for each *Premium* payment after the first *Premium*. Coverage will remain in effect during the grace period. The coverage under this *Policy* will terminate at the end of the grace period if the *Premium* has not been paid. The *Policyholder* must still pay all unpaid *Premium*. This includes the *Premium* due for the grace period. No grace period is provided after the *Policyholder* has given notice of intent to end the *Policy*.

TERMINATION OF INSURANCE

The *Company* or the *Policyholder* may terminate the *Policy* on any date by written notice mailed or delivered. If the *Company* terminates the *Policy* for a reason other than non-payment of *Premium*, the termination becomes effective on the later of the date stated in the notice or 45 days after the *Company* mails or delivers the written notice of such termination. If any portion of the *Premium* due is not paid, the *Policy* will terminate in accordance with the Grace Period provision. If the *Policyholder* terminates the *Policy*, the termination becomes effective at 11:59 PM on the later of the date stated in the notice or the date the *Company* receives the written notice of such termination. If the *Policy* is terminated, the *Company* will promptly refund any unearned *Premium*, or the *Policyholder* will promptly pay any earned *Premium* which has not yet been paid. Any unearned and earned *Premium* will be calculated on a pro-rata basis.

Termination of the *Policy* will be without prejudice to the rights of any *Insured* as respects any *Claim* arising during the period the *Policy* is in force.

The *Policyholder* has the sole responsibility to notify *Employees* of such termination.

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Globe Life And Accident Insurance Company, a Nebraska Stock Company

Home Office: 3700 S Stonebridge Dr, McKinney, TX 75070

Group Limited Indemnity Certificate

CERTIFICATE OF INSURANCE

Globe Life And Accident Insurance Company (*We, Us, Our, Company*) hereby certifies that it has issued and delivered to the *Policyholder* a group *Policy*, described on the *Schedule of Benefits* page. The group *Policy* covers certain eligible persons as described in the *Policy*.

This *Certificate* describes the benefits and provisions of the group *Policy*. It becomes *Your Certificate* of Insurance only if:

1. *You* are eligible for the insurance;
2. *You* are *Actively In Service* on the date it is to take effect if *You* are an *Employee*; and
3. *You* become insured and remain insured in accordance with the provisions of the *Policy*.

The insurance is to be effective only if the required *Premium* payments are made by *You* or on *Your* behalf to *Us*. No agent may change the *Policy* or waive any of its provisions.

IN WITNESS WHEREOF, *We* have caused this *Certificate* to take effect on the Certificate Effective Date.

Secretary

President

THIS IS A LIMITED BENEFIT CERTIFICATE. It provides fixed-benefit payments. Benefits provided are not intended to cover all hospital or other medical expenses.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If *You* are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the *Company*.

FIFTEEN DAY RIGHT TO EXAMINE CERTIFICATE. If *You* decide that *You* do not want this *Certificate* for any reason, *You* may return it to *Us* within fifteen (15) days after the date *You* receive it for a full refund of any *Premium* paid. When it is returned, it will be considered void as though it were never issued.

The Policy is a contract between the Policyholder and the Company. This *Certificate* is renewable at the option of the *Company*. Please read the Termination of Insurance provision of this *Certificate*. This *Certificate* does not contain a *Pre-Existing Condition Limitation*. The *Company* may change rates, subject to the *Policy's* Premium Rate Changes provision. No such change in *Premium* will be made unless 60 days prior notice is given to the *Policyholder*.

READ YOUR CERTIFICATE CAREFULLY.

THE POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL TO HEALTH INSURANCE AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THE POLICY DOES NOT SATISFY THE MINIMUM ESSENTIAL COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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SCHEDULE OF BENEFITS

POLICYHOLDER NAME:	Wichita Falls Independent School District		
POLICYHOLDER NUMBER:	BZ0019	**POLICY ANNIVERSARY DATE:**	September 1
CERTIFICATE NUMBER:	BZ0019-01	**CERTIFICATE EFFECTIVE DATE:**	September 1, 2024

ELIGIBILITY: All Permanent *Employees*, who are *Actively in Service* and working 19 hours or more per week, and *Spouses* and *Dependent Child(ren)* of eligible *Employees*

Benefits	Benefit Amounts/Maximums
HOSPITAL CONFINEMENT BENEFIT	
Benefit Amount	$200 per Insured, per day
Benefit Year Maximum	10 days per Insured
HOSPITAL INTENSIVE CARE UNIT CONFINEMENT BENEFIT	
Benefit Amount	$400 per Insured, per day
Benefit Year Maximum	5 days per Insured
HOSPITAL ADMISSION BENEFIT	
Benefit Amount	$1,500 per Insured, per day
Benefit Year Maximum	1 day per Insured

DEFINITIONS

ACCIDENT means a sudden unexpected event, which occurs on or after the *Insured's Coverage Effective Date* and while the *Certificate* is in force, that is the direct cause of an *Injury* to an *Insured*.

ACTIVELY IN SERVICE means that *You* are:
1. performing in the usual manner, all of the *Material and Substantial Duties* of *Your* employment for the regularly scheduled number of hours on a scheduled work day; and
2. the *Material and Substantial Duties* are being performed at one of the places of business where *You* normally perform such duties or at some location to which *Your* employment sends *You*.

You will be said to be Actively in Service on a day that is not a scheduled work day only if *You* are able to perform in the usual manner all of the regular duties of *Your* employment if it were a scheduled work day.

ANNUAL ENROLLMENT PERIOD means the period of time agreed upon by the *Policyholder* and *Us* each year during which an *Employee* may add, change or cancel insurance under the *Policy*.

BENEFIT YEAR means the period beginning on the *Certificate Effective Date* and ending on the Policy Anniversary. Each Policy Anniversary begins a new Benefit Year. The Policy Anniversary Date is shown on the *Schedule of Benefits*.

CERTIFICATE means the Certificate of coverage issued to *You*. It describes *Your* coverage under the *Policy*.

CERTIFICATE EFFECTIVE DATE means the date shown on the *Schedule of Benefits*. The *Certificate Effective Date* will start at 12:00 a.m. Standard Time at the main place of business of the *Policyholder*.

CLAIM means a request for payment of benefits for *Covered Services*.

CLAIMANT means a person who has filed a *Claim* under the *Policy*.

COMPLICATIONS OF PREGNANCY means any of the following:
1. a condition that, while affected by pregnancy, is still classified by accepted medical standards as a *Sickness* apart from the normal bodily changes that accompany pregnancy;
2. a non-elective Caesarean section;

3. an extra-uterine or ectopic pregnancy; or
4. a spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include: false labor, premature labor, high risk pregnancy or delivery, occasional spotting, physician-prescribed rest, morning sickness, pre-eclampsia or placenta previa or similar conditions that occur in a difficult pregnancy.

CONFINED OR CONFINEMENT means the assignment to a bed as a resident inpatient in a *Hospital*, or confinement in an *Observation Unit* within a *Hospital*, for a period of 23 or more continuous hours, on the advice of a *Physician*.

COVERAGE EFFECTIVE DATE means the date *Your* coverage begins under the *Policy*. The Coverage Effective Date will start at 12:00 a.m. Standard Time of the place where *You* reside. If *You* are not *Actively in Service* on the date coverage would otherwise become effective, the Coverage Effective Date will be the date on which *You* are first thereafter *Actively in Service*.

COVERED SERVICES means *Treatment* for which benefits are payable under the *Policy*.

DEPENDENT means *Your Spouse* and/or *Dependent Child(ren)* who meet the definition of *Spouse* and *Dependent Child(ren)* as defined in this *Certificate*.

DEPENDENT CHILD(REN) means all of *Your* children who are unmarried and less than 26 years of age. However, if any Dependent Child is incapable of self-sustaining employment due to intellectual disability or physical handicap and is dependent on *You* for support and maintenance, such age limit of 26 shall not apply. Proof of such incapacity and dependency must be furnished to *Us* within 31 days following the child's 26th birthday, and not more frequently than annually following the 2 year period after such child attains the specified limiting age.

Child(ren) means *Your* biological children, stepchildren, adopted children, foster children, or children for whom *You* must provide medical or dental support under an order issued under Chapter 154, Family Code or enforceable by a court in this state.

Child(ren) also means *Your* unmarried grandchildren who are *Your* dependents for federal income tax purposes at the time the application for coverage of the grandchild is made. Children are considered to be Dependent Children if *You* are party to a suit seeking adoption of the child.

DURABLE MEDICAL EQUIPMENT means *Medically Necessar*y equipment that provides therapeutic benefits to a patient in need due to *Injury* or *Sickness*. Durable Medical Equipment consists of items that are:
1. primarily and customarily used to serve a medical purpose;
2. not useful to a person in the absence of *Injury* or *Sickness*;
3. ordered or prescribed by a *Physician*;
4. designed for repeated use by more than one person;
5. appropriate for use in the home; and
6. rented or purchased for use by the *Insured*.

Examples of Durable Medical Equipment include but are not limited to:
1. equipment to assist mobility, such as a standard wheelchair;
2. standard hospital-type bed;
3. oxygen, and the equipment to administer oxygen;
4. delivery pumps for tube feedings;
5. braces, including necessary adjustment to shoes to accommodate braces; braces that stabilize an injured body part;
6. medical equipment for the *Treatment* of chronic or acute respiratory failure (except air conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items);
7. equipment and supplies for the *Treatment* of Type I, Type II or gestational diabetes.

EMERGENCY ROOM means a facility that provides initial *Treatment* to patients requiring immediate attention for *Sickness* or *Injury*. An Emergency Room is specially equipped and staffed to provide emergency care and is:
1. located on the premises of a *Hospital*;
2. physically part of a *Hospital*; or
3. a free-standing facility.

EMPLOYEE means a person who is *Actively in Service* as an Employee of the *Policyholder*.

ENROLLMENT PERIOD means an *Annual Enrollment Period*, a *New Hire Enrollment Period* or other specified period established by the *Policyholder* and agreed to by *Us* during which eligible *Employees* may enroll or change insurance under the *Policy* for themselves and their *Dependents*.

HOSPITAL means a general acute care facility that meets all of the following:
1. is licensed as a hospital pursuant to applicable law;
2. is primarily and continuously engaged in providing medical care and *Treatment* to sick and injured persons;
3. is managed under the supervision of a staff of medical doctors;
4. provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. has medical, diagnostic and treatment facilities, with major surgical facilities on its premises or available on a prearranged basis; and
6. charges for its services. This requirement is waived for Veterans Administration Hospitals and Federal Government Hospitals.

Hospital does not include any of the following:
1. a rest or nursing home, home for the aged, or convalescent home;
2. a *Skilled Nursing Care Facility*, rehabilitation center, extended care facility, or assisted living center;
3. a hospice, custodial care facility, or birthing center; or
4. a *Mental Disorder Treatment Facility*.

HOSPITAL INTENSIVE CARE UNIT means a place which:
1. is a specifically designated area of the *Hospital* that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care;
2. is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
3. is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
4. 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
5. has a *Physician* assigned to the intensive care unit on a full-time basis.

A Hospital Intensive Care Unit that meets the definition above may include hospital units with the following names:
1. Intensive Care Unit;
2. Coronary Care Unit;
3. Neonatal Intensive Care Unit;
4. Pulmonary Care Unit;
5. Burn Unit; or
6. Transplant Unit.

A Hospital Intensive Care Unit is not any of the following step-down units:
1. a progressive care unit;
2. an intermediate care unit;
3. a private monitored room;
4. a sub-acute intensive care unit;
5. an *Observation Unit*; or
6. any facility not meeting the definition of a Hospital Intensive Care Unit as defined in this *Certificate*.

INJURY means bodily injury, due to an *Accident*, sustained by an *Insured*, directly and independently of disease, bodily infirmity, or other cause of the loss, that occurs while this *Certificate* is in force. It includes all complications of and all Injuries from the same *Accident*.

INPATIENT SURGERY means a surgical procedure performed on an *Insured* who is *Confined* as a registered bed patient in a *Hospital* or other medical facility.

INSURED(S) means *You*, *Your Spouse* and/or *Your Dependent Child(ren)* who have been properly enrolled and for whom *Premium* has been paid.

INVESTIGATIONAL OR EXPERIMENTAL means care, treatment, services or supplies not approved or recognized for the treatment of *Injury* or *Sickness* by any of the following:

1. the American Medical Association;
2. the United States Surgeon General;
3. the United States Department of Health and Human Services;
4. the National Institutes of Health;
5. the Health Care Finance Administration; or
6. Medicare.

Drugs are considered *Investigational or Experimental* if they are not:
1. commercially available for purchase; and
2. approved by the U.S. Food and Drug Administration for general use.

LATE ENTRANT means an *Employee* who:
1. was eligible but did not enroll during an established *Enrollment Period*; or
2. did not enroll themselves or their eligible *Dependents* within 31 days of a *Life Status Change*.

LIFE STATUS CHANGE means an event that qualifies *You* to make changes in coverage during a time other than an *Enrollment Period*. The following are considered Life Status Changes:
1. a change in the benefit plan or employment status of an *Insured* that affects their eligibility for benefits;
2. marriage;
3. divorce or annulment;
4. death of a *Spouse*;
5. birth, adoption (or petition for adoption) or foster of a child;
6. change in a *Dependent Child's* eligibility;
7. death of a *Dependent Child*, if the child was the only *Dependent Child* covered under the *Certificate* issued to *You*;

MATERIAL AND SUBSTANTIAL DUTIES means the duties that:
1. are normally required for the performance of *Your* employment; and
2. cannot be reasonably omitted or modified.

MEDICALLY NECESSARY means any services, tests, office visits, drugs, or supplies:
1. determined by the treating *Physician* as necessary to diagnose, treat symptoms or medical conditions, or provide preventative care in a manner generally accepted by the medical community;
2. ordered, prescribed, recommended, or approved by the treating *Physician* to diagnose or treat symptoms or a specific medical condition;
3. not simply for the convenience of *Physician* or patient; and
4. not used for *Investigational or Experimental Treatment*.

Medically Necessary includes *Treatment*, drugs, services or supplies related to gender transition (including gender dysphoria), medically appropriate gender-specific services, and other related dysfunctions.

In order to determine that care is Medically Necessary, *We* reserve the right to obtain, at *Our* expense, a second opinion from a *Physician* who:
1. is not an employee or owner of a facility or agency from which *You* or an *Insured* receives care; and
2. specializes in the condition that is the subject of *Your Claim*.

Should the *Physician We* choose disagree with the treating *Physician*, *We* reserve the right to rely solely on *Our Physician's* opinion for claim purposes.

MENTAL DISORDER means any diagnosed condition listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for which *Treatment* is commonly sought from a *Mental Health Provider*. Diagnoses described in the DSM will be considered mental disorders, regardless of etiology. Mental Disorders include *Substance Use Disorders*.

MENTAL DISORDER TREATMENT FACILITY means a facility that provides inpatient *Treatment* for *Mental Disorder*s and which:
1. is established and operated pursuant to applicable state laws;
2. provides the following basic services:
   a. room and board;

b. evaluation and diagnosis;
c. counseling; and
3. has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the *Insured*.

A Mental Disorder Treatment Facility does not include a unit or wing within a *Hospital*, a half-way house, a group home, a recovery farm, or any similar facility.

MENTAL HEALTH PROVIDER means a person duly qualified and licensed to provide *Treatment* for a *Mental Disorder* that is the subject of a *Claim*. Mental Health Provider does not include *You*, *Your Dependent(s)*, or any member of *Your* household or immediate family.

NEW HIRE ENROLLMENT PERIOD means the period of time established by the *Policyholder* and agreed to by *Us* during which *Employees* who have been newly hired or who are newly eligible due to a change in benefit class or hours may enroll for coverage under the *Policy*.

OBSERVATION UNIT means a specified area within a *Hospital*, apart from the *Emergency Room*, where a patient can be monitored following outpatient surgery or *Treatment* in the *Emergency Room* by a *Physician*, and which:
1. is under the direct supervision of a *Physician* or registered nurse;
2. is staffed by nurses assigned specifically to that unit; and
3. provides care seven days per week, 24 hours per day.

PHYSICIAN means an individual practicing within the scope of their license in the state where so licensed and duly qualified to provide care, *Treatment*, services, or supplies for the *Injury* or *Sickness* that is the subject of *Your Claim*.

POLICY means the policy issued to the *Policyholder* that covers the *Insured*.

POLICYHOLDER means the employer which has contracted with *Us* to provide benefits to *You*.

PREMIUM means the periodic fees required to maintain coverage for each *Insured* in accordance with the terms of the *Policy*.

SCHEDULE OF BENEFITS means the benefit schedule set forth in this *Certificate*.

SICKNESS means an illness or disease that starts while the *Insured's* coverage is in force. *Sickness* includes pregnancy and *Complications of Pregnancy*.

SKILLED NURSING CARE FACILITY means a place where an *Insured* goes to recover from a *Sickness* or *Injury* and that:
1. is a legally operated facility that can be part of a *Hospital*;
2. operates 24 hours a day and will accept inpatients on an overnight basis;
3. is supervised by a *Physician*;
4. has a 24-hour a day nursing staff which is supervised by a registered nurse; and
5. keeps written daily records for each patient.

Notwithstanding the above, a Skilled Nursing Care Facility is not:
1. a rest home or a home for the aged;
2. a place that provides mostly custodial care; or
3. a place for *Treatment* of a *Mental Disorder*.

SPOUSE means the person recognized as *Your* spouse under the laws of the state in which *You* reside.

SUBSTANCE USE DISORDER means a recurrent use of alcohol and/or drugs which causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

TREATMENT means medical advice, diagnosis, or *Medically Necessary* care or services (including diagnostic measures and taking prescribed drugs) provided by a *Physician* and received by an *Insured*.

YOU, YOUR means the insured *Employee* who has been properly enrolled and for whom *Premium* has been paid.

BENEFITS

This section describes the Benefits provided by the *Policy*. Benefits are subject to the terms, conditions, limitations, exclusions, and maximums in the *Policy* and *Certificate*, and shown on the *Schedule of Benefits*. Benefits are not payable for any *Sickness* or *Injury* that occurs, or *Confinement* that begins, prior to the *Insured's Coverage Effective Date*.

HOSPITAL CONFINEMENT BENEFIT

We will pay the benefit shown on the *Schedule of Benefits* if an *Insured* incurs charges for and is *Confined* and receiving *Treatment* in a *Hospital* due to *Sickness* or *Injury*. *Confinement* in a *Hospital* must begin on or after the *Insured's Coverage Effective Date*.

The Benefit Amount payable per day will not exceed the Hospital Confinement Benefit Amount for each day the *Insured* is *Confined*, subject to the maximum number of days per *Benefit Year* shown on the *Schedule of Benefits*. The Hospital Confinement Benefit is payable for routine newborn care and nursery charges for a healthy newborn child.

The Hospital Confinement Benefit will not be paid for:

1. *Emergency Room Treatment;*
2. outpatient *Treatment*; or
3. *Confinement* of less than 23 hours in an *Observation Unit*.

For any one day of *Confinement* for the same *Sickness* or *Injury*, *We* will pay only the largest of the following Benefits if applicable: the Hospital Intensive Care Unit Confinement Benefit, or the Hospital Confinement Benefit.

HOSPITAL INTENSIVE CARE UNIT CONFINEMENT BENEFIT

We will pay the benefit shown on the S*chedule of Benefits* if any *Insured* incurs charges for and is *Confined* to a *Hospital Intensive Care Unit* due to *Sickness* or *Injury*. *Confinement* in a *Hospital Intensive Care Unit* must begin on or after the *Insured's Coverage Effective Date*.

The Benefit Amount payable per day will not exceed the Hospital Intensive Care Unit Benefit Amount, subject to the maximum number of days per *Benefit Year* shown on the *Schedule of Benefits*.

If an *Insured* is *Confined* in an area of a *Hospital* that does not meet this *Certificate's* definition of a *Hospital Intensive Care Unit*, *We* will pay the Hospital Confinement Benefit Amount shown on the *Schedule of Benefits* for each day the *Insured* is *Confined*, subject to the maximum number of days per *Benefit Year* shown on the *Schedule of Benefits*.

For any one day of *Confinement* for the same *Sickness* or *Injury*, *We* will pay only the largest of the following Benefits if applicable: the Hospital Intensive Care Unit Confinement Benefit or the Hospital Confinement Benefit.

If the maximum number of days shown on the *Schedule of Benefits* has been met under the Hospital Confinement Intensive Care Unit Benefit, any additional days of *Hospital Intensive Care Unit Confinement* will be paid under the Hospital Confinement Benefit. However, *We* will not pay more than the Benefit Year Maximum as shown on the *Schedule of Benefits* for Hospital Confinement.

HOSPITAL ADMISSION BENEFIT

We will pay the Benefit Amount shown on the *Schedule of Benefits* for the first day an *Insured* is admitted and *Confined* as an inpatient to a *Hospital* due to *Sickness* or *Injury*.

The Hospital Admission Benefit is limited to one benefit per *Confinement*, regardless of the length of *Confinement*. The Benefit Amount payable per day will not exceed the Hospital Admission Benefit Amount, subject to the maximum number of days per *Benefit Year* shown on the *Schedule of Benefits*. The Hospital Admission Benefit is not payable for delivery of a healthy newborn child.

This Benefit will not be paid for services received as an outpatient, in an *Emergency Room*, or while confined in an *Observation Unit*.

EXCLUSIONS

The *Policy* does not provide any benefits for the following:

1. services or supplies that are not *Medically Necessary*, even if prescribed, recommended, or approved by a *Physician*; or services provided by, or furnished at the direction of, *You*, *Your Dependent(s)*, or any member of *Your* household or immediate family in the role as a *Physician*;
2. intentionally self-inflicted *Injury* or suicide attempt while sane or insane;
3. voluntary abortion except:
   a. where an *Insured's* life would be endangered if the fetus were carried to term, or
   b. where medical complications have arisen from abortion;
4. procedures, services, or drugs related to artificial insemination, in vitro or test tube fertilization, including any related testing;
5. procedures, services, or drugs for exogenous obesity or weight control;
6. services for purchase and fitting of hearing aids;
7. services and supplies related to smoking cessation;
8. charges for food, food supplements, or vitamins;
9. charges related to marriage, family, child, career, social adjustment, pastoral, or financial counseling;
10. services related to therapy, supplies, treatment or counseling for sexual dysfunction or inadequacies that do not have a physiological or organic basis;
11. procedures, services, or drugs for the reversal of a tubal ligation or a vasectomy;
12. charges for rental or purchase of *Durable Medical Equipment*;
13. *Injury* or *Sickness* resulting from
    a. an act of war, declared or undeclared;
    b. active participation in a riot, civil commotion, civil disobedience or unlawful assembly;
    c. committing a felony;
    d. participation in a contest of speed in a power driven vehicle, parachuting, parasailing, bungee jumping, scuba diving, stunt driving, rock climbing, flying ultra-light aircraft, skydiving, hang gliding or any hazardous sports activity for exhibition purposes;
    e. air travel, except as a fare-paying passenger on a commercial airline; or
    f. the *Insured* being intoxicated (as determined and defined by the laws of the jurisdiction where the *Injury* occurred); or under the influence of any drug, controlled substance or narcotic unless taken or used as prescribed of a *Physician*;
14. cosmetic surgery or elective surgery, including any expenses related to *Hospital Confinement*, unless due to a covered *Injury* or *Sickness*, organ donation or *Medically Necessary* gender reassignment;
15. any treatment, drugs, or surgery considered *Investigational or Experimental*;
16. any *Injury* or *Sickness* occurring while the *Insured* is in the service of the Armed Forces of any country. Orders to active military service for training purposes of two months or less will not constitute service in the Armed Forces. When the *Insured* provides *Us* notice of entering the Armed Forces, *We* will return to the *Insured* pro rata any *Premium* paid, less any benefits paid, for any period during which the *Insured* is in such service;
17. an *Injury* or *Sickness* for which the *Insured* receives benefits under Workers' Compensation or similar coverage or for which the *Insured* would receive benefits under Workers' Compensation if the employer had enrolled the *Insured* for such coverage and the *Insured* and employer had cooperated in filing a claim under that coverage;
18. dental or vision services, including but not limited to treatment, surgery, extractions or x-rays, unless:
    a. resulting from an *Injury* occurring while the *Insured's* coverage is in force and if performed within 12 months of the date of such *Injury*;
    b. due to congenital disease or anomaly of a newborn *Dependent Child*; or
    c. dental services or oral surgery due to excision of impacted third molars, closed or open reduction of fractures, or dislocation of the jaw;
19. any charges incurred prior to the *Insured's Coverage Effective Date* or in excess of the Benefit Year Maximums shown on the *Schedule of Benefits*;
20. pregnancy of a *Dependent Child*, except *Complications of Pregnancy*;
21. routine examinations, such as health exams, periodic check-ups or routine physicals;
22. treatment for *Mental Disorder*, unless specifically stated in this *Certificate*; or
23. treatment for *Substance Use Disorder*, unless specifically stated in this *Certificate*.

ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY

Employees or *Dependents* who meet the definition of Eligibility as stated on the *Schedule of Benefits* are eligible to be insured under the *Policy*. Evidence of insurability acceptable to *Us* may be required.

*Late Entrant*s may not make coverage changes after the *Enrollment Period* ends unless they:

1. enroll within 31 days of a *Life Status Change*; or
2. provide satisfactory proof that within 31 days before the request they became ineligible for another insurance plan in which they were enrolled due to age or a change in employment.

ELIGIBILITY OF DEPENDENTS

You may enroll *Your* eligible *Dependents* provided:

1. *You* are insured under the *Policy*;
2. *Dependent* coverage is provided under the *Policy*; and
3. *Your Dependents* are also eligible for coverage.

An individual cannot be covered as an *Employee* and a *Dependent* at the same time.

An eligible *Dependent Child* may only be covered under one *Employee's Certificate* if both parents are covered separately under the *Policy*.

EFFECTIVE DATE

If *You* are an *Employee*, *Your* Coverage *Effective Date* is the latest of the following:

1. the *Certificate Effective Date*;
2. the *Enrollment Period* effective date, if *You* enroll during an *Enrollment Period*;
3. the date *You* become eligible for coverage;
4. the effective date of *Your* enrollment in the *Policy*;
5. the first day of the first coverage period for which *Your Premium* is received.

If *You* are not *Actively in Service* on the date coverage would otherwise become effective, the *Coverage Effective Date* will be the date on which *You* are first thereafter *Actively in Service*.

If *You* are a *Late Entrant*, *Your Coverage Effective Date* will be the Policy Anniversary Date after the date *You* enroll.

The *Coverage Effective Date* for a *Dependent* is the date we assign after approving their enrollment under the *Policy* subject to the following:

1. The eligible *Dependent* has been enrolled and *Premium* has been paid; and
2. The *Dependent* must not be *Hospital Confined*. If a *Dependent* is *Hospital Confined*, coverage is effective at 12:00 a.m. Standard Time of the place where *You* reside, on the day the *Dependent* is no longer *Hospital Confine*d, if otherwise eligible for coverage on the date *Your* coverage became effective.
3. For *Dependent Child(ren)* eligible on or first acquired after *Your Coverage Effective Date*:
    a. For newborn children, the *Coverage Effective Date* is the moment of birth. *We* must receive notification of birth within 31 days after the date of birth for coverage to continue for the newborn beyond the 31 day period.
    b. For newborn adopted children, the *Coverage Effective Date* is the moment of birth if a petition for adoption is filed within 31 days of the child's birth. For other adopted children, the *Coverage Effective Date* is the earlier of the placement in *Your* home, the date a petition for adoption is filed or the date the decree of adoption is entered. *We* must receive notification of such placement, petition or decree within 31 days from the date of placement into *Your* home or the date petition for adoption is filed or the date the decree is entered, for coverage to continue beyond the 31 day period.
    c. For foster children, the *Coverage Effective Date* is the date of placement in *Your* home. *We* must receive notification of foster children within 31 days from the date of placement into *Your* home for coverage to continue for the foster children beyond the 31 day period.

TERMINATION OF INSURANCE

Your coverage will terminate at 11:59 PM on the earliest of:

1. the date the *Policy* is terminated;

2. the end of the last period for which *Premium* has been paid in accordance with the Grace Period;
3. on the date *You* cease to be *Actively in Service* if *You* are an *Employee*, as defined in this *Certificate*, except as provided for under the Leave of Absence provision in this section; or
4. on the date *You* no longer meet the requirements for eligibility.

Coverage for an insured *Dependent* will terminate at 11:59 PM the earliest of:
1. the date the *Policy* is terminated;
2. the date *Your* coverage is terminated;
3. the end of the last period for which *Premium* has been paid in accordance with the Grace Period;
4. the *Premium* due date following the date the *Dependent* ceases to meet the definition of an eligible *Dependent*; or
5. the *Premium* due date following the date *We* receive *Your* written request to terminate coverage for a *Dependent*.

Termination of insurance on any *Insured* shall be without prejudice to his rights as regarding any *Claim* arising prior thereto.

We or the *Policyholder* may terminate the *Policy* on any date by written notice mailed or delivered. If *We* terminate the *Policy* for a reason other than non-payment of *Premium*, the termination becomes effective on the later of the date stated in the notice or 45 days after *We* mail or deliver the written notice of such termination. If any portion of the *Premium* due is not paid, the *Policy* will terminate in accordance with the Grace Period provision. If the *Policyholder* terminates the *Policy*, the termination becomes effective at 11:59 PM on the later of the date stated in the notice or the date *We* receive the written notice of such termination. If the *Policy* is terminated, *We* will promptly refund any unearned *Premium*, or the *Policyholder* will promptly pay any earned *Premium* which has not yet been paid. Any unearned and earned *Premium* will be calculated on a pro-rata basis.

Termination of the *Policy* will be without prejudice to the rights of any *Insured* as respects any *Claim* arising during the period the *Policy* is in force.

The *Policyholder* has the sole responsibility to notify *You* of such termination.

EXTENSION OF BENEFITS FOR HOSPITAL CARE
If on the date an *Insured's* coverage terminates, the *Insured* is *Confined* to a *Hospital* and has incurred charges for *Covered Services*, *We* will continue to pay the applicable Hospital Confinement Benefit or Hospital Intensive Care Unit Confinement Benefit until the earliest of:
1. the date the *Insured* is discharged from the *Hospital*;
2. the applicable maximum number of days per *Benefit Year* shown on the *Schedule of Benefits* is reached; or
3. 90 days after the date the *Insured's* coverage terminates.

The total benefits payable for each *Insured* during a *Benefit Year*, including any Extension of Benefits for Hospital Care, will not exceed the Benefit Year Maximum per *Insured* listed for the Hospital Confinement Benefit or the Hospital Intensive Care Unit Confinement Benefit shown on the *Schedule of Benefits*.

No further *Premium* payment is required to qualify for this extension of benefits.

This provision does not apply if the termination was for non-payment of *Premium*.

LEAVE OF ABSENCE
Subject to the continued payment of *Premiums* due, *Your* coverage may be continued for up to 12 months during a Leave of Absence approved in writing by *Your* employer.

CONTINUATION OF COVERAGE – WORK STOPPAGE
In the event of a work stoppage due to a labor dispute, *You* may continue this coverage until the earliest of the following:
1. the date 6 months after the work stoppage occurs;
2. the date that 75% of the *Policyholder's Employees* elect to continue coverage; or
3. the date *You* take full-time employment with another employer.

You are responsible for paying the full required *Premiums* when due, including any *Premiums* due and unpaid on or before the date of the work stoppage.

The *Company* may increase the *Premiums* up to 20% during the work stoppage to cover increased administrative costs.

PREMIUMS

PREMIUMS
Premium rates are expressed, and *Premiums* are payable, in United States currency. The *Premiums* for coverage under this *Certificate* will be based on the rates for the Benefits set forth in the *Schedule of Benefits*, including any amounts due for covered *Dependents*.

The first *Premium* is due on the *Certificate Effective Date*. *Premiums* after the first are due at the end of the period for which the preceding *Premium* was paid. If any *Premium* is not paid when due, *Your* coverage under the *Policy* will be terminated as of the *Premium* due date of the unpaid *Premium*, except as provided under the Grace Period.

The total *Premium* paid by the *Policyholder* is the sum of *Premiums* for all *Insureds* covered under the *Policy*, including any amounts *Insureds* have contributed toward the cost of coverage. The *Policyholder* is responsible for paying all *Premiums*. However, the *Premiums* may be paid by any other party according to a mutual agreement among the other party, the *Policyholder* and *Us*.

DEPENDENTS
The due date for any additional *Premium* for a *Dependent* eligible on or first acquired after *Your Coverage Effective Date* will be 31 days after coverage for that *Dependent* is required to begin. The total *Premiums* due may change from time to time due to addition of new or deletion of covered eligible *Dependents*.

PREMIUM PAYMENT
Premiums are payable on a monthly basis, unless *We* agree to some other mode of payment.

Premiums may be paid to:
1. *Our* Administrative Office; or
2. *Our* authorized agent.

Payment of *Premium* for a period before it is due will not guarantee that the coverage will remain in effect for that period, if coverage terminates for reasons other than nonpayment of *Premium*.

PREMIUM CHANGES
We may change rates, subject to the *Policy's* Premium Rate Changes provision. No such change in *Premium* will be made unless 60 days prior notice is given to the *Policyholder*.

GRACE PERIOD
A grace period of 31 days will be allowed for each *Premium* payment after the first *Premium*. Coverage will remain in effect during the grace period. However, if *We* do not receive *Premium* due before the end of the grace period, *Your* coverage will be terminated as of the last date for which *Premium* has been paid. No grace period is provided after the *Policyholder* has given notice of intent to end the *Policy*.

REFUNDS
Refunded *Premium* will be returned to the party who made the payment to *Us*.

Premiums will not be refunded for any period prior to 30 days before the written request is received in our Administrative Office or for any coverage period during which *We* have paid *Claims*.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of *Claim* must be given to *Us* at the Administrative Office address listed on the first page of the *Policy*. Such notice should be made within 30 days after any loss covered by the *Policy*. If it is not reasonably possible to give notice within that time, the *Claim* may not be denied or reduced due to the delay.

CLAIM FORMS: Claim forms should be used for filing proof of loss. They will be sent to the *Insured* within 15 days of receipt of notice of *Claim*. If claim forms are not supplied within 15 days, the *Insured* can give proof as follows:
1. in writing;
2. setting forth the nature and extent of the *Claim*, including the *Physician's* diagnosis; and
3. within the time stated in the Proof of Loss provision.

PROOF OF LOSS: Proof of loss must be given to *Us* within 180 days after the loss. Late proof may be accepted if:
1. it was not reasonably possible to give proof in that time; and
2. the proof is given within one year from the date proof is otherwise required. This one year limit will not apply in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS: Benefits payable under the *Policy* will be paid promptly upon but not later than 60 days after receipt of acceptable Proof of Loss.

ASSIGNMENT OF BENEFITS: Benefits under the *Policy* may be assigned.

PAYMENT OF CLAIMS: All benefits will be payable to *You* unless assigned. Any accrued benefit unpaid at *Your* death may be paid to *Your* designated beneficiary, surviving *Spouse* or *Your* estate. The *Company* will be discharged to the extent of any such payment made in good faith.

We may pay benefits for a *Dependent Child* to a person who is not an *Insured* if an order providing for the appointment of a possessory or managing conservator of the *Dependent Child* has been issued by a court. The person must provide *Us* with written notice that they are a possessory or managing conservator of the *Dependent Child* on whose behalf the claim is made and a certified copy of the court order designating such person as the possessory or managing conservator of the *Dependent Child*, or any other evidence that the person is eligible to receive benefits for the *Dependent Child*.

PHYSICAL EXAMINATIONS AND AUTOPSY: *We* have the right, at *Our* expense, to have an *Insured* examined as often as reasonably necessary while a *Claim* is pending and to make an autopsy in case of death where it is not forbidden by law.

REIMBURSEMENT OF OVERPAYMENT: The *Insured* will be responsible for reimbursing *Us* for any payment of benefits in excess of the Benefit Year Maximums listed on the *Schedule of Benefits*. The *Insured* will also be responsible for reimbursing *Us* for any overpayment resulting from fraud or an error in *Claim* processing made by the *Insured*, *Us* or the plan administrator.

PAYMENT OF BENEFITS TO THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION: All benefits payable on behalf of a covered *Dependent Child* must be paid to the Texas Health and Human Services Commission whenever:
1. the Texas Health and Human Services Commission is paying benefits on behalf of the covered *Dependent Child* under the Human Resources Code, Chapter 31 or 32, which are the financial and medical assistance service programs administered pursuant to the Human Resources Code;
2. the *Insured* has possession or access to the covered *Dependent Child* pursuant to a court order, or is not entitled to access or possession and is required to pay child support; and
3. the *Company* receives written notice, affixed to the insurance *claim*, when the *claim* is first submitted, which states that all benefits paid pursuant to this provision must be paid directly to the Texas Health and Human Services Commission.

GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:
1. the *Policy*;
2. the application of the *Policyholder*;
3. the *Certificates*;
4. *Your* enrollment form, if any; and
5. all riders, endorsements and amendments.

Unless fraudulent, all statements made by an *Insured* to obtain coverage under the *Policy* are considered representations and not warranties.

The terms of the *Policy* can be changed only by rider, endorsement or amendment signed by an executive officer of the *Company*. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the *Policyholder*. No agent may change the *Policy* or waive its provisions.

CERTIFICATES: A *Certificate* will be issued for delivery to *You*. The *Certificate* will describe:
1. the benefits under the *Policy*;
2. to whom benefits will be paid; and
3. the limitations and terms of the *Policy*.

If more than one *Certificate* is issued under the *Policy* to *You*, only the last one issued will be in effect.

If there is a conflict between the *Policy* and the *Certificate*, the *Policy* will control.

ADDITIONAL COVERAGE WITH US: If an *Insured* is covered by more than one of *Our* group limited indemnity *Policies* or *Certificates*, *We* will only pay benefits for covered charges under one group limited indemnity *Certificate*. An *Insured* may choose which *Certificate* they wish to keep in force by sending *Us* written notice of their choice. *We* will return the *Premiums* paid for any of the *Insured's* other group limited indemnity *Certificate(s)* during the period there was more than one *Policy* or *Certificate* in force.

LEGAL ACTION: No legal action may be brought to recover under the *Policy*:
1. within 60 days after written Proof of Loss has been furnished as required; or
2. more than 3 years from the time written Proof of Loss is required to be furnished.

INCONTESTABILITY: No statement will be used to deny or reduce benefits or be used as a defense to a *Claim* unless it is contained in a written instrument signed by the individual making the statement and a copy of the instrument containing the statement is, or has been, furnished to the *Insured*. In the event of an *Insured's* death or incapacity, their applicable representative shall be given a copy. After two years from an *Insured's Coverage Effective Date*, no such statement will be used to contest the coverage or deny a *Claim* for loss incurred commencing after the expiration of such two year period except in the case of fraud or material misrepresentation.

CLERICAL ERROR: A clerical error by the *Policyholder* will not end coverage or continue terminated coverage. In the event of such clerical error, a *Premium* adjustment will be made.

MISSTATEMENT OF AGE: In the event the age of the *Insured* has been misstated and if, according to the correct age of the *Insured*, the coverage provided by the *Policy* would not have become effective or would have ceased prior to the acceptance of *Premium* or *Premiums*, then *Our* liability shall be limited to the refund of all *Premiums* paid for the period not covered by the *Policy*.

WORKERS' COMPENSATION: The *Policy* is not a Workers' Compensation policy. The *Policy* does not satisfy any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH STATE LAWS: A provision of the *Policy* that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

EXAMINATION OF THE POLICY: The *Policy* will be available for inspection at the *Policyholder's* office during regular business hours.

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program.

Globe Life

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY
HEALTH INSURANCE NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice gives you information required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA Privacy Rules) about the duties and privacy practices of Globe Life And Accident Insurance Company to protect the privacy of your medical information that we maintain as an issuer of health insurance policies that provide medical care benefits. We sent this Notice to you because our records show that we provide health care benefits to you under an individual or group health insurance policy that provides medical care benefits.

This Notice applies to the designated health care components of Globe Life And Accident Insurance Company that use and disclose your medical information to provide medical care benefits to you under health insurance policies. We use the terms health and health care in this Notice to refer to the medical care benefits we provide to you. This Notice does not apply to the information that our non-health care components maintain about you as an issuer of life, disability, accident, indemnity or any other non-health insurance policy.

THE EFFECTIVE DATE OF THIS NOTICE IS NOVEMBER 1, 2021. We are required to follow the terms of this Notice until we replace it. We reserve the right to change the terms of this Notice at any time. If we make changes to this Notice, we will revise it and send a new Notice to all persons to whom we are required to give the new Notice. We reserve the right to make the new changes apply to all your medical information maintained by us before and after the effective date of the new Notice.

Purposes for which We May Use or Disclose Your Medical Information Without Your Consent or Authorization

We may use and disclose your medical information for the following purposes:

- **Health Care Providers' Treatment Purposes.** For example, we may disclose your medical information to your doctor, at the doctor's request, for your treatment by him or her.
- **Payment.** For example, we may use or disclose your medical information to collect premiums, to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment. We may also use and disclose your medical information to another covered entity or health care provider for the payment activities of the entity that receives your medical information.
- **Health Care Operations.** For example, we may use or disclose your medical information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (iii) to authorize business associates to perform data aggregation services, (iv) to engage in care coordination or case management, and (v) to manage, plan or develop our business. We may also disclose your medical information to another covered entity for the limited health care operations activities and health care fraud and abuse compliance activities of the entity that receives your medical information.
- **Health Services.** We may use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may disclose your medical information to our business associates to assist us in these activities.
- **As required by law.** For example, we must allow the U.S. Department of Health and Human Services to audit our records. We may also disclose your medical information as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.
- **To Business Associates.** We may disclose your medical information to business associates we hire to assist us. Each of our business associates must agree in writing to ensure the continuing confidentiality and security of your medical information.
- **To Plan Sponsor.** If we provide health benefits to you under a group health plan, we may disclose to the plan sponsor of your group health plan, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. We may also disclose to the plan sponsor the fact that you are enrolled in, or disenrolled from the group health plan. We may disclose your medical information to the plan sponsor for administrative functions that the plan sponsor provides to the group health plan if the plan sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The plan sponsor must also agree not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the plan sponsor.

We may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to us to do this.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.

Potential Impact of State Law

In some situations, the HIPAA Privacy Rules do not preempt (or take precedence over) state privacy laws that give you greater privacy protections. As a result, the privacy laws of a particular state might impose a privacy standard under which we will be required to operate (for example, a state privacy law relating to disclosures of medical information of minors).

Uses and Disclosures with Your Permission

We will not use or disclose your medical information for any other purposes unless you give us your written authorization to do so. Authorization will be obtained from you before most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, disclosures for the sale of protected health information, or any uses and disclosures not described in this Notice. If you give us written authorization to use or disclose your medical information for a purpose that is not described in this Notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information we maintain, unless we have taken action in reliance on your authorization.

Your Rights

You may make a written request to us to do one or more of the following concerning your medical information that we maintain:

- To put additional restrictions on our use and disclosure of your medical information. We do not have to agree to your request.
- To communicate with you in confidence about your medical information by a different means or at a different location than we are currently doing. We do not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow us to collect premiums and pay claims. Your request must specify the alternative means or location. Even though you requested that we communicate with you in confidence, we may give subscribers cost information.
- To see and get copies of your medical information. In limited cases, we do not have to agree to your request.
- To correct your medical information. In some cases, we do not have to agree to your request.
- To receive a list of disclosures of your medical information that we and our business associates made for certain purposes for the last 6 years.
- To send you a paper copy of this Notice if you received this Notice by email or on the Internet.

In addition, Globe Life may not use or disclose genetic information of an individual for underwriting purposes. We will notify affected individuals following a breach of unsecured protected health information.

If you want to exercise any of these rights described in this Notice, please contact the Contact Office (below). We will give you the necessary information and forms for you to complete and return to the Contact Office. In some cases, we may charge you a nominal, cost-based fee to carry out your request.

Complaints

If you believe we have violated your privacy rights, you have the right to complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us at our Contact Office (below). We will not retaliate against you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office

To request additional copies of this Notice or to receive more information about our privacy practices or your rights, please contact us at the following Contact Office:

Globe Life And Accident Insurance Company
ATTENTION: Privacy Office, Compliance Department
PO Box 8080
McKinney, TX 75070-8080
Telephone: 844-593-8916

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Globe Life And Accident Insurance Company To get information or file a complaint with your insurance company or HMO:

Call: The Loomis Company,
at 1-800-208-2066
Toll - free: 1-800-208-2066

Mail: P.O Box 7011,

Wyomissing, PA 19610-6011

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1 - 800 - 252 - 3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection,
MC: CO-OP, Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tambien debe presentar una queja a traves del proceso de quejas o de apelaciones de su compania de seguros o HMO. Si no lo hace, podria perder su derecho para apelar.

Globe Life And Accident Insurance Company
Para obtener informacion o para presentar una queja ante su compania de seguros o HMO:

Llame a: The Loomis Company

al 1-800-208-2066

Telefono gratuito: 1-800-208-2066

Direccion postal: P.O. Box 7011,

Wyomissing, PA 19610-6011

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1 - 800 - 252 - 3439
Presente una queja en: www.tdi.texas.gov
Correo electronico: ConsumerProtection@tdi.texas.gov

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