BlueCross BlueShield of Texas

Voluntary Hospital Indemnity Insurance

Employee Benefit Booklet

CARES

VF030277-0001

Class 1-01

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Texas is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

11/20/2025

This plan is an "employee welfare benefit plan," ("Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

This document serves to provide important information about the Plan. It is not the entire Plan document, but a summary of important information about the Plan. In addition to this summary plan description ("SPD"), ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. Your employer or Plan Administrator maintains the full Plan Document. If there is a conflict between the Plan Document and this SPD, the Plan Document controls. A copy of the Plan Document is available for review during normal working hours in the office of the Plan Administrator.

The benefits described in your Plan document are provided under a group Plan sponsored by the Employer and insured by Blue Cross and Blue Shield of Texas.

SUMMARY PLAN DESCRIPTION	
1. PLAN NAME: If different, the name by which the plan is commonly known.	Employee Welfare Plan
2. PLAN TYPE:	Welfare Benefit Plan providing a Policy and Certificate
3. PLAN SPONSOR/EMPLOYER'S NAME AND ADDRESS: Name and address of employer sponsoring the Plan or employee organization maintaining the Plan	CARES 1845 E. Northgate Drive Irving, TX 75062
4. EMPLOYER IDENTIFICATION NUMBER (EIN): Employer identification number assigned by the IRS to the Plan Sponsor	68-0589116
5. PLAN NUMBER: Number assigned by the Plan Sponsor. This number is used for Form 5500 reporting. Each Plan should be assigned a unique number that is not used more than once.	501
6. ERISA PLAN YEAR ENDS ON EACH: This is the end of the Plan Year for maintaining the Plan's fiscal records and may be different from the insurance policy year.	December 31
7. PLAN ADMINISTRATOR'S NAME, ADDRESS, AND TELEPHONE NUMBER:	CARES 1845 E. Northgate Drive Irving, TX 75062 (972) 721-5255
8. AGENT FOR SERVICE OF LEGAL PROCESS ON THE PLAN:	CARES 1845 E. Northgate Drive Irving, TX 75062
9. SOURCES OF FUNDING AND CONTRIBUTIONS: Contributions are, for example, employer, employee organization or employee contributions and the method by which the amount of the contributions is calculated. Funding is the medium by which the Plan is funded. For example, the identity of the insurance company or trust fund through which the Plan is funded or benefits are provided.	The Plan is funded as an insured plan under policy number VF030277 issued by Blue Cross and Blue Shield of Texas. Contributions to the Plan are made as stated on the Schedule of Benefits in the Group Insurance Certificate. The employer determines the method of funding and contributions, if any, to be made by the participants.

10. TYPE OF ADMINISTRATION:	This plan is administrated by insurer administration.
11. CLAIM ADMINISTRATION:	The Claim Administrator is not the "plan administrator" of your Plan, as defined in Section 3(16)(A) of ERISA. The Plan Administrator has selected Blue Cross and Blue Shield of Texas as the claims administrator of your Plan and has delegated to Blue Cross and Blue Shield of Texas the authority and discretion to administer the terms of the applicable group policy provisions such as making initial claim determinations concerning the availability of benefits, and the final review and benefit determinations for appealed claims.
12. EACH TRUSTEE'S NAME, TITLE, AND ADDRESS OF PRINCIPAL PLACE OF BUSINESS: This is only applicable if the Plan has trustees.	
13. LABOR ORGANIZATION: This is applicable if the Plan is subject to a CBA.	
14. PLAN AMENDMENT AND TERMINATION PROCEDURE:	The Employer reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan (including any related documents and underlying policies), in whole or in part, at any time, without prior notice. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan. The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures. Rights with respect to termination of insurance benefits are stated in the Policy and Certificate. The employer can request a Policy change, including a change to benefits, rights and obligations under the Policy but only an officer of Blue Cross and Blue Shield of Texas can approve a change to the Policy. The change must be in writing and endorsed on or attached to the Policy
15. ELIGIBILITY FOR PARTICIPATION AND BENEFITS:	These requirements are found in the Policy and Certificate incorporated herein by reference.
16. CIRCUMSTANCES CONCERNING INELIGIBILITY, DISQUALIFICATION, OR DENIAL OR LOSS OF BENEFITS:	These requirements are found in the Policy and Certificate incorporated herein by reference.
17. CLAIMS PROCEDURES: The procedures which govern claims for benefits and requests for review of denied claims.	The Plan's claims procedures are furnished automatically, without charge, as a separate document. Refer to the ERISA Information Statement incorporated herein by reference.

Dearborn Life Insurance Company

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

Chicago, Illinois

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

Having issued Group Policy No. VF030277

(herein called the *Policy*)

to

CARES
(herein called the *Policyholder*)

GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE

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

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

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

READ THIS CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

Secretary President

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

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

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

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SCHEDULE OF BENEFITS

POLICYHOLDER:	CARES
POLICY NUMBER:	VF030277
POLICY EFFECTIVE DATE:	01/01/2026
ANNUAL ENROLLMENT PERIOD:	November 1 - November 30

ELIGIBILITY:
Class 01

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

Eligibility Waiting Period:

Current *Employees*: None

New *Employees*: First of the month following or coinciding with 0 Days of continuous, full-time Active Work

Policyholder Contribution:

Voluntary Hospital Indemnity 0% of premium

HOSPITAL INDEMNITY:

Coverage For:

Employee, Spouse, and Dependent Child

Dependent Child benefits from live birth to age 26

Reduction of Benefits:

Benefits terminate at retirement.

Portability:

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

HOSPITAL INDEMNITY BENEFITS

Hospital Admission	$1000 Payable once per calendar year
Hospital Intensive Care Unit (ICU) Admission	$1000 Payable once per calendar year
Hospital Confinement	$100 per day Up to 30 days per calendar year
Hospital Intensive Care Unit (ICU) Confinement	$100 per day Up to 10 days per calendar year
Newborn Confinement Benefit	$50 per day Up to 3 days
Wellness Benefit	$50 per day once per calendar year per *Covered Person*

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

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

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

When does Your Contributory insurance become effective?

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

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

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

Change in Family Status

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

Change in Family Status means:

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

When does Dependent Hospital Indemnity Insurance become effective?

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

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

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

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

When does coverage for a new Spouse become effective?

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

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

When does coverage for a newborn Child become effective?

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

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

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

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

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

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

What is an Enrollment Period?

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

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

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

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

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

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

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

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

What happens if We are replacing a Prior Policy?

Effect on Actively at Work requirement-Continuity of Coverage

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

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

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

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

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

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

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

Changes to Your coverage

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

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

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

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

A decrease in coverage will take effect immediately.

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

Eligibility after You Terminate Employment

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

PORTABILITY BENEFIT

What is the Portability Benefit?

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

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

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

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

What are Eligibility Requirements for Employee Portability?

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

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

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

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

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

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

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

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

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

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

When will Portable Coverage Terminate?

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

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

HOSPITAL INDEMNITY INSURANCE BENEFITS

What is the Hospital Admission Benefit?

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

This benefit is payable only once per calendar year.

The benefit amount is listed in the Schedule of Benefits.

What is the Intensive Care Unit Admission Benefit?

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

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

This benefit is payable only once per calendar year.

The benefit amount is listed in the Schedule of Benefits.

What is the Hospital Confinement Benefit?

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

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

The benefit amount is listed in the Schedule of Benefits.

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

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

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

The benefit amount is listed in the Schedule of Benefits.

What is the Newborn Confinement Benefit?

The *Newborn Confinement Benefit* is payable when a newborn *Child* is born to a *Covered Person* and is receiving newborn nursery care. Newborn nursery care does not include treatment for an *Injury* or *Illness*.

The benefit amount is listed in the Schedule of Benefits.

WELLNESS BENEFIT

What is the Wellness Benefit?

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

Wellness Tests include:

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

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

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

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

LIMITATIONS AND EXCLUSIONS

Are there any Limitations and Exclusions for Hospital Indemnity Insurance?

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

1. cosmetic surgery or other elective procedure that is not medically necessary; or
2. suicide or attempted suicide, while sane or insane; or
3. any intentionally self-inflicted *Injury*; or
4. combat training or war, declared or undeclared, whether or not a member of any armed forces; or
5. travel or flight in any aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
6. commission of, participation in, or an attempt to commit an assault or felony as defined by state or federal law; or
7. a loss that occurs while a *Covered Person* is legally incarcerated in a penal or correctional institution; or
8. The *Covered Person* being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a *Physician* and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
9. The *Covered Person* being intoxicated as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated; or
10. active participation in a *Riot*. ***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder; or
11. driving or riding in any vehicle used in a race, speed or endurance test or for acrobatic or stunt driving; or
12. a *Mental* or *Nervous Disorder*; or
13. any *Substance Abuse.*

Exclusions:

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

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

Limitation for Pregnancy and Childbirth

There is no coverage for *Pregnancy*, or *Childbirth* during the first 9 months that a *Covered Person* is insured under this *Certificate*.

TERMINATION PROVISIONS

When does Your coverage under the Policy end?

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

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

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

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

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

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

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

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

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

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

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

While granted a Family or Medical Leave of Absence:

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

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

When does Dependent Hospital Indemnity Insurance coverage end?

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

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

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

GENERAL PROVISIONS

Entire Contract; Changes

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

Statements on the Application

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

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

Legal Actions

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

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

Clerical Error

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

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

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

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

Time Limit on Certain Defenses

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

Premium Provisions

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

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

Misstatement of Age

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

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

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

Conformity with State Statutes and Regulations

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

UNIFORM CLAIM PROVISIONS

Initial Notice of Claim

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

Claim Forms

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

Time Limit for Filing Your Claim

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

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

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

Time of Payment of Claim

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

Physical Examination/Autopsy

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

Who will receive Your Hospital Indemnity Insurance Benefits?

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

Facility of Payment

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

Do I have the Right to Appeal a Claim Denial?

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

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

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

You may:

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

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

The decision on appeal will provide the following:

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

GENERAL DEFINITIONS

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

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

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

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

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

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

Certificate means this *Hospital Indemnity Insurance Certificate*.

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

Child(ren) means:
1. *Your* natural, adopted, foster or step *Child* or *Child* of *Your Registered Domestic Partner* under the age stated in the Schedule of Benefits;
2. a *Child* under the age stated in the Schedule of Benefits placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the *Child*. Eligibility will continue unless the *Child* is removed from placement;
3. an unmarried *Child* of *Your Child* who is within the age limits set forthin the Schedule of Benefits and who is *Your* dependent for federal income tax purposes at the time application for coverage of the *Child* of *Your Child* is made. Coverage for a *Child* of *Your Child* may not be terminated solely because the *Child* is no longer a *Dependent* for tax purposes; or
4. a *Child* for who *You* are required to insure under a medical support order issued under Chapter 154, Family Code or enforceable by a court of the State of Texas.

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

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

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

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

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

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

Hospital means an institution that meets all of the following:

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

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

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

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

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

Intensive Care Unit or ICU means a place which:

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

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

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

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

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

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

Male Pronoun whenever used includes the female.

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

Mental and Nervous Disorder means neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder, without a demonstratable organic disease, published in the most recent *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) by the American Psychiatric Association (APA). If the APA no longer publishes a diagnostic manual or the APA ceases to exist, *We* will use a comparable diagnostic manual.

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

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

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

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

Pregnancy means the condition or period of being pregnant.

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

Registered Domestic Partner means an adult of the same or opposite gender who has an emotional, physical and financial relationship to *You*, similar to that of a *Spouse*, as evidenced by the following:

1. *You* and *Your Domestic Partner* share financial responsibility for a joint household and intend to continue an exclusive relationship indefinitely;
2. *You* and *Your Domestic Partner* each are at least eighteen (18) years of age;
3. *You* and *Your Domestic Partner* are both mentally competent to enter into a binding contract;
4. *You* and *Your Domestic Partner* share a residence and have done so for at least 12 months;
5. Neither *You* nor *Your Domestic Partner* are married to or legally separated from anyone else;
6. *You* and *Your Domestic Partner* are not related to one another by blood closer than would bar marriage; and
7. Neither *You* nor *Your Domestic Partner* is a *Domestic Partner* of anyone else.

Where the laws of the governing jurisdiction mandate a definition of *Registered Domestic Partner* other than shown above, that definition will be used in the *Policy*.

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

Spouse means lawful *Spouse*. *Spouse* will include *Your Registered Domestic Partner*.

Substance Abuse means alcoholism, or the non-medical use of narcotics, sedatives, stimulants, hallucinogens or any other such substance, whether or not prescribed by a Physician.

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

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

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

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). This notice summarizes your protections.

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

Texas Life and Health Insurance Guaranty Association
1717 West 6th Street, Suite 230
Austin, TX 78703-4776
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
P.O. Box 12030
Austin, Texas 78711
1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

GEN-76-0223

Cómo estar protegido si su compañía de seguro de vida o de salud falla

La Asociación de Garantía de Seguros de Vida y Salud de Texas lo protege pagando sus reclamos cubiertos si su compañía de seguro de vida o salud es insolvente (no puede pagar sus deudas). **Este aviso resume sus protecciones**.

La Asociación pagará sus reclamos, con algunas excepciones requeridas por la ley, si su compañía de seguros tiene licencia en Texas y un tribunal la ha declarado insolvente. Debe vivir en Texas cuando su compañía de seguros falla. Si no vive en Texas, aún puede tener algunas protecciones.

Por cada compañía insolvente, la Asociación pagará los reclamos de una persona solo hasta estos límites en dólares establecidos por ley:

- **Seguros de accidentes, accidentes y salud, o salud (incluidos los HMO):**
  - Hasta $500,000 para planes de beneficios de salud, con algunas excepciones.
  - Hasta $300,000 para beneficios de ingresos por discapacidad.
  - Hasta $300,000 para beneficios de seguro de cuidado a largo plazo.
  - Hasta $200,000 para todos los demás tipos de seguro de salud.
- **Seguro de vida:**
  - Hasta $100,000 en valor neto de rescate o retiro de efectivo.
  - Hasta $300,000 en beneficios por muerte.
- **Anualidades individuales:** hasta $250,000 en el valor presente de los beneficios, incluidos los valores de rescate en efectivo y retiro neto de efectivo.
- **Otros tipos de pólizas:** los límites para pólizas grupales, planes de jubilación y anualidades de liquidación estructurada se encuentran en el Capítulo 463 del Código de Seguros de Texas.
- **Límite agregado individual:** hasta $300,000 por persona, independientemente de la cantidad de pólizas o contratos. Se puede aplicar un límite de $500,000 para personas con planes de beneficios de salud.
- **Es posible que partes de algunas pólizas no estén protegidas:** por ejemplo, no hay protección para partes de una póliza o contrato que la compañía de seguros no garantiza, como algunas adiciones al valor de las pólizas de vida o anualidades variables.

Para obtener más información sobre la Asociación y sus protecciones, comuníquese con:

Texas Life and Health Insurance Guaranty Association
1717 West 6th Street, Suite 230
Austin, TX 78703-4776
1-800-982-6362 www.txlifega.org

Para preguntas sobre seguros comuníquese con:

Texas Department of Insurance
P.O. Box 12030
Austin, Texas 78711
1-800-252-3439 or www.tdi.texas.gov

Nota: usted recibió este aviso porque la ley de Texas requiere que su compañía de seguros le envíe un resumen de sus protecciones bajo la Ley de Asociación de Garantía de Seguro de Vida y Salud de Texas (Código de Seguro, Capítulo 463). **Puede haber otras excepciones que no están incluidas en este aviso**. Al elegir una compañía de seguros, no debe confiar en la cobertura de la Asociación. La ley de Texas prohíbe a las compañías y agentes utilizar la Asociación como incentivo para comprar cobertura de seguro o HMO.

El Capítulo 463 controla si hay diferencias entre la ley y este resumen.

GEN-76-0223 SP

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.

Dearborn Life Insurance Company
To get information or file a complaint with your insurance company or HMO:
Call: Contract Specialist at:
1-630-691-0365
Toll-free: 1-877-442-4207
Email: DOIComplaintsTX@bcbstx.com
Mail: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

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-CP Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía 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 inglés) pueda ayudar.

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

Dearborn Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: Contract Specialist at:
1-630-691-0365
Teléfono gratuito: 1-877-442-4207
Correo electrónico: DOIComplaintsTX@bcbstx.com
Dirección postal: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

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 electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

END OF CERTIFICATE

STATEMENT OF ERISA RIGHTS

As a participant in the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.*, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

1. Receive Information about Your Plan and Benefits

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

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

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

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

   Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in federal court. In such 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 if, for example, it finds Your claims are frivolous.

4. Assistance with Your Questions

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

ERISA INFORMATION STATEMENT

The benefits described in Your certificate are insured by an Insurance Policy ("Policy") issued by Blue Cross and Blue Shield of Texas (“We” or "Insurer"), pursuant to an "Employee welfare benefit plan" (“the Plan”) as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1002(1) established by Your employer, or where applicable, employee organization (the “Policyholder").

Every employee welfare benefit plan must be established and maintained pursuant to a written instrument that provides for a Plan Administrator. Your Plan Administrator has delegated the authority to administer claims under the Policy to the Insurer. As claims administrator, We will make decisions concerning eligibility and benefit determinations in accordance with the Policy provisions.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is the person or entity responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the Employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy and/or Certificate must also be approved in writing by an officer of the Insurer and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. As stated above, the Plan's benefits are provided to You pursuant to an insurance Policy issued to the Company. The Insurer shall, with respect to the Policy:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a), 29 U.S.C. §1105(a). The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits, except as provided in the Plan.

B. CLAIMS PROCEDURE:

When You or Your Beneficiary are eligible to receive benefits, You or Your Beneficiary, or Your authorized representative (collectively, "You") must follow the claim procedures described in Your Group Insurance Certificate by submitting the proper form in writing to the Insurer at:

Claims Department
Blue Cross and Blue Shield of Texas
701 E. 22nd Street
Lombard, IL. 60148
1-877-442-4207

For the purpose of this Section, the terms "written" and "in writing" include "electronic." Any action required to be "written" or "in writing," may be done electronically, where available. If the Insurer uses electronic notices, it will do so in accordance with 29 CFR 2520.104b-1c(i), (iii) and (iv).

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148