EMPLOYER: TEXAS HOT OILERS

GROUP NUMBER: 791565

CERTIFICATE OF INSURANCE
Humana Insurance Company

This Certificate is not an insurance policy. It is an outline of the insurance provided by the group policy and it does not extend or change the coverage afforded by such group policy. The insurance described by this Certificate is subject to all the provisions, terms, exclusions and conditions of the group policy.

This Certificate supersedes and replaces any Certificate previously issued under the provisions of the group policy.

THE DEATH BENEFIT IN FORCE UNDER THE POLICY WILL BE REDUCED IF ACCELERATED BENEFIT ARE PAID.

The Accelerated Benefits offered in this Certificate may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Benefit qualifies for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

Receipt of Accelerated Benefits may affect you, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplemental Social Security Income (SSI) and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect you, your spouse and your family's eligibility for public assistance.

Bruce Broussard
President

GROUP INSURANCE CERTIFICATE

POLICYHOLDER (EMPLOYER): TEXAS HOT OILERS

GROUP NUMBER: 791565

BENEFITS	**EFFECTIVE DATE**
BASIC TERM LIFE COVERAGE for Employee	12-01-2023
ACCIDENTAL DEATH AND BODILY INJURY COVERAGE for Employee	12-01-2023

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.

DentiCare, Inc (d/b/a as CompBenefits)

To get information or file a complaint with your insurance company or HMO:

Call: Customer Care at **1-800-233-4013/ TTY Number: 711**
Toll-free: **1-800-223-4013 / TTY Number: 711**

Email: HumanaResolution@Humana.com

Mail: Humana Grievance and Appeal Department
P. O. Box 14546
Lexington, KY 40512-4546

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: MC 111-1A, P.O. Box 12030, Austin, TX 78711-12030

¿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.

DentiCare, Inc (d/b/a as CompBenefits)

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Atención al cliente al **1-800-233-4013/ TTY Number: 711**
Teléfono gratuito: **1-800-223-4013 / TTY Number: 711**
Correo electrónico: HumanaResolution@Humana.com

Dirección postal: Humana Grievance and Appeal Department
P. O. Box 14546
Lexington, KY 40512-4546

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: MC 111-1A, P.O. Box 12030, Austin, TX 78714-12030

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SCHEDULE OF BENEFITS

EMPLOYEE BASIC TERM LIFE INSURANCE

BASIC TERM LIFE INSURANCE BENEFIT:

$50,000 Amount of coverage	x Salary (rounded to the next highest $1,000)	
Class	% Salary	Benefit Amount

THE BASIC TERM LIFE INSURANCE BENEFIT IS REDUCED TO THE FOLLOWING FOR YOUR **EMPLOYEES:**

Reduced by 50% AT AGE 70 based on the amount of Basic Term Life Insurance in force at age 69

EMPLOYEE ACCIDENTAL DEATH OR BODILY INJURY BENEFIT

ACCIDENTAL DEATH OR BODILY INJURY BENEFIT:

$50,000 Amount of coverage x Salary (rounded to the next highest $1,000)

Class	% Salary	Benefit Amount

ACCIDENTAL DEATH OR **BODILY INJURY** BENEFIT IS REDUCED TO THE FOLLOWING FOR YOUR **EMPLOYEES:**

Reduced by 50% AT AGE 70 based on the amount of Basic Term Life Insurance in force at age 69

DEFINITIONS

The following are definitions of terms as they are used in this Certificate. Defined terms are printed in bold face type wherever found in this Certificate.

A

Active Status means the **Employee** is performing all of the material duties of his/her occupation whether performed at the **Employer's** business establishment or another location of business when required to travel on behalf of the **Employer:**

- On a regular, full-time basis;
- For the number of hours per week shown on the Employer Group Application; and
- For 48 weeks a year.

An **Employee** will be considered in **Active Status** with the **Employer** on a day which is one of the **Employer's** scheduled work days if the **Employee** is performing, in the usual way, all of the material duties of his/her occupation on a full-time basis. The **Employee** will also be considered actively at work on each day of a regular scheduled paid vacation, or any regular non-working holiday, only if the **Employee** was at work on the preceding scheduled work day and was not **Totally Disabled** including a hospital confinement on that day.

B

Bodily Injury means injury due directly to a specific accident, independent of all other causes. Muscle strain due to athletic or physical activity, or bodily damage resulting from infection, is considered a **Sickness**.

C

Confinement means being a resident patient in a **Hospital** or **Qualified Treatment Facility** for at least 15 consecutive hours. **Confinement** does not mean detainment in Observation Status.

Successive **Confinements** are considered to be one **Confinement** if:

- Due to the same **Bodily Injury** or **Sickness**; and
- Separated by fewer than 30 consecutive days when **You** are not confined.

Covered Person means the **Employee** and/or the **Employee's** covered **Dependents**.

D

DEPENDENT

Dependent means a covered **Employee's**:

1. Legally recognized spouse; or

2. Natural blood related child, step-child, or legally adopted child, child or grandchild placed with the **Employee** for the purpose of adoption whose age is less than the limiting age. **Dependent** DOES NOT mean a great grandchild, or foster child.

The limiting age for each **Dependent** child is 26 years of age.

You must furnish satisfactory proof to **Us** upon **Our** request that the above conditions continuously exist. If satisfactory proof is not submitted to **Us**, the child's coverage will not continue beyond the last date of eligibility.

A covered **Dependent** child who becomes an employee eligible for other group coverage through employment is no longer eligible as a **Dependent** for coverage under the Policy.

A covered **Dependent** child who attains the limiting age WHILE INSURED under the Policy remains eligible for Benefits if mentally or physically disabled and under the **Employee's** supervision.

You must furnish satisfactory proof to **Us** upon **Our** request that the above conditions continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, **We** may not request such proof more often than annually. If satisfactory proof is not submitted to **Us**, the child's coverage will not continue beyond the last date of eligibility.

E

Employee means a person who is in **Active Status** for the **Employer** on a permanent full-time basis. The **Employee** must be paid a salary or wage by the **Employer** that meets the minimum wage requirements of **Your** state or federal minimum wage law for work done at the **Employer's** usual place of business or some other location which is usual for the **Employee's** particular duties.

Employer means the Policyholder of this Group Insurance Plan, or any subsidiary described in the Employer Group Application.

H

Hospital means an institution which:

- Maintains permanent full-time facilities for bed care of resident patients;
- Has a physician or surgeon in regular attendance;
- Provides continuous 24-hour-a-day nursing services;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
- Is legally operated in the jurisdiction where located; and
- Has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services; or
- Is a lawfully operated **Qualified Treatment Facility** certified by the First Church of Scientist, Boston, Massachusetts.

Hospital does NOT include an institution which is principally a rest home, nursing home, convalescent home or home for the aged. **Hospital** does NOT include a place principally for the treatment of alcohol or chemical dependency or Mental Disorders.

M

Material And Substantial Duties are the duties that:

- Are normally required for the performance of the occupation; and
- Cannot be reasonably omitted or changed.

You will no longer be considered **Totally Disabled** or Partially Disabled under this Plan when **You** are able to increase **Your** current earnings by increasing the number of hours **You** work or the number of duties **You** perform in **Your** regular occupation but **You** do not do so.

DEFINITIONS (continued)

P

Policyholder means the **Employer** who is the Legal Entity named as the **Policyholder** on the face page of the Policy.

Q

Qualified Practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a **Bodily Injury** or **Sickness**, and who provides services within the scope of that license. A **Qualified Practitioner** does not include a practitioner who resides in **Your** home or is **Your** Family Member.

Qualified Treatment Facility means only a facility, institution, or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

S

Sickness means a disturbance in function or structure of **Your** body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of **Your** body.

Surgery means excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

T

Total Disability or **Totally Disabled** means, for the **Employee** that during the disability he or she is at all times prevented by **Bodily Injury** or **Sickness** from performing each and every **Material And Substantial Duty** of his or her occupation as it is generally performed in the economy.

A **Totally Disabled** person may not engage in ANY job or occupation for wage or profit.

W

We, Us, and **Our** means the Insurance Company as shown on the cover page of this Certificate.

Y

You and **Your** means any **Covered Person**.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

EMPLOYEE COVERAGE

EMPLOYEE ELIGIBILITY DATE

The **Employee** is eligible for coverage on the date:

- Eligibility requirements stated in the Employer Group Application are satisfied; and
- The **Employee** is in an **Active Status**.

EMPLOYEE ENROLLMENT

The **Employee** must enroll on forms furnished and accepted by **Us**. Depending on the total number of **Employees** covered by the **Employer's** plan, **We** may require any **Employee** to provide evidence of insurability and any applicable evidence of health status whenever an enrollment form is submitted.

If **You** enroll more than 31 days after **Your** eligibility date, **You** are a late applicant and must provide **Us** with evidence of insurability and any applicable evidence of health status. This form is available from the **Employer** or **Us**. **We** have the right to accept or decline coverage. If accepted, **You** will be covered on the date **We** specify.

EMPLOYEE EFFECTIVE DATE

The **Employee's** Effective Date Provision is stated in the Employer Group Application. It may be the date immediately following, or the first of the month following, completion of the probationary period (waiting period), or the date approved by **Us.**

EMPLOYEE DELAYED EFFECTIVE DATE

If the **Employee** is not in **Active Status** on the effective date shown on the Schedule of Benefits, coverage will be effective the day after the **Employee** returns to **Active Status**. The **Employer** must notify **Us** in writing of the **Employee's** return to **Active Status**.

EMPLOYEE BENEFIT CHANGES

Additional or increased insurance will become effective on the approved date of change if the **Employee** is in **Active Status** on that date. Otherwise, the approved change will be effective on the day after the **Employee** returns to **Active Status**.

We may require any **Employee** to provide evidence of insurability and any applicable evidence of health status whenever a benefit change is requested.

A decrease in insurance will be effective immediately on the approved date of change.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE (continued)

DEPENDENT COVERAGE

DEPENDENT ELIGIBILITY DATE

Each **Dependent** is eligible for coverage on:

- The date the **Employee** is eligible for coverage, if he or she has **Dependents** who may be covered on that date;
- The date of the **Employee's** marriage for any **Dependents** (spouse or child) acquired on that date;
- The date of birth of the **Employee's** natural-born child; or
- The date the child is legally adopted or placed in the **Employee's** home for the purpose of adoption by the **Employee**.

The **Employee** may cover his or her **Dependents** ONLY if the **Employee** is also covered.

A **Dependent** child who becomes eligible for other group coverage through any employment is no longer eligible for group coverage under the Policy. If a **Dependent** child becomes an **Employee** of the participating **Employer**, he or she is no longer eligible as a **Dependent** and must make application as an eligible **Employee**.

DEPENDENT ENROLLMENT

Check with the **Employer** immediately on how to enroll for **Dependent** Coverage. Late enrollment may result in denial of **Dependent** Coverage by **Us.**

The **Employee** must enroll for **Dependent** Coverage and enroll additional **Dependents** on forms furnished and accepted by **Us.** No **Dependent** will become a **Covered Person** until **We** approve the **Dependent** for coverage.

Depending on the total number of **Employees** covered by the **Employer's** plan, **We** may require any **Dependent** to provide evidence of insurability and any applicable evidence of health status whenever an enrollment form is submitted.

If **You** enroll more than 31 days after **Your** eligibility date, **You** are a late applicant and must provide **Us** evidence of insurability and any applicable evidence of health status. This form is available from the **Employer** or **Us**. **We** have the right to accept or decline coverage. If accepted, **You** will be covered on the date **We** specify.

NEWBORN DEPENDENT ENROLLMENT

Employees who already have full **Dependent** (spouse and children) coverage in force PRIOR to the newborn's date of birth are not required to complete an enrollment form for the newborn child.

All other **Employees** who are changing their current coverage must complete an enrollment form for the newborn **Dependent**. This form is available from **Your Employer** or from **Us.**

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE (continued)

DEPENDENT EFFECTIVE DATE

Each **Dependent's** effective date of coverage is determined as follows, subject to the **Dependent** Delayed Effective Date provision:

- If **We** receive the enrollment form ON, PRIOR TO or WITHIN 31 days of the **Dependent's** eligibility date, that **Dependent** is covered on the date he or she is eligible;

- If **We** receive the enrollment form MORE THAN 31 days after the **Dependent's** eligibility date, **We** require evidence of insurability and any applicable evidence of health status. **We** have the right to accept or decline coverage for the **Dependent** based upon the evidence of insurability and any applicable evidence of health status. If accepted, the effective date of coverage will be the date **We** specify.

However, NO **Dependent's** effective date will be prior to the **Employee's** effective date of coverage.

Refer to **Your** Schedule of Benefits for benefits available.

NEWBORN DEPENDENT EFFECTIVE DATE

A newborn **Dependent's** effective date is determined as follows:

- If **We** receive the enrollment form ON, PRIOR TO or WITHIN 31 days of the newborn's date of birth, **Dependent** Coverage is effective on the newborn's date of birth.
- If **We** receive the enrollment form MORE THAN 31 days after the newborn's date of birth, **We** require evidence of insurability and any applicable evidence of health status. **We** have the right to accept or decline coverage for the newborn based upon the evidence of insurability and any applicable evidence of health status. If accepted, the newborn will be covered on the date **We** specify.

DEPENDENT DELAYED EFFECTIVE DATE

If the **Dependent:**

- Is confined in a **Hospital** or **Qualified Treatment Facility**; or
- Is receiving Home Health Care or Hospice benefits, the **Dependent's** effective date of coverage will be delayed.

The **Dependent's** coverage will be effective on the day after:

- Discharge from **Confinement**, if the discharge from **Confinement** is certified by a **Qualified Practitioner**; or
- A **Qualified Practitioner** certifies that Home Health Care is no longer required.

If **Dependent** coverage is in force or applied for within 31 days of the newborn child's date of birth, the Dependent Delayed Effective Date provision will not apply to the newborn child on its date of birth.

DEPENDENT BENEFIT CHANGES

Additional or increased insurance will become effective on the approved date of change, subject to the **Dependent** Delayed Effective Date provision.

We may require any **Dependent** to provide evidence of insurability and any applicable evidence of health status whenever a benefit change is requested.

A decrease in insurance will be effective immediately on the approved date of change.

TERMINATION OF COVERAGE

Termination of Coverage may be immediate or at the end of the period which was selected by Your Employer on the Employer Group Application.

Insurance terminates on the earliest of the following:

- The date the Group Policy terminates;
- The end of the period for which required premium was due **Us** and not received by **Us**;
- For an **Employe**e, the date he or she terminates employment with the **Employer**;
- For an **Employee**, the date he or she no longer qualifies as an **Employee**;
- The date **You** fail to be in an eligible class of persons as provided in the Insurance Classifications as stated in the Employer Group Application;
- The date **You** enter full-time military, naval or air service except that termination will not occur if **You** are in temporary active duty as a reservist for military training that lasts 30 days or less;
- The date the **Employee** retires, except if the Employer Group Application provides coverage for a retiree class of **Employees** and the retiree is in an eligible class of retirees, selected by the **Employer**, and **We** are notified by the **Employer**;
- The date the **Employee** requests termination of insurance to be effective for the **Employee** or **Dependents**;
- For a **Dependent**, the date the **Employee's** insurance terminates;
- For a **Dependent**, the date he or she no longer qualifies as a **Dependent**; or
- For any benefit, the date the benefit is deleted from the Policy.

YOU AND THE **EMPLOYER** ARE RESPONSIBLE TO ADVISE **US** OF ANY CHANGES IN ELIGIBILITY INCLUDING THE LACK OF ELIGIBILITY OF ANY **COVERED PERSON**. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY REGARDLESS OF THE LACK OF NOTICE TO **US**.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If the **Employer** continues to pay required premiums and continues coverage under the Policy, **Your** coverage, other than Short Term Disability benefits, if any, will remain in force for:

- No longer than three consecutive months if the **Employee** is:
  - Temporarily laid-off;
  - In part-time status; or
  - On an **Employer** approved leave of absence.
- No longer than twelve consecutive months if the **Employee** is **Totally Disabled**.

If the **Employee** becomes **Totally Disabled** and wishes to apply for Waiver of Premium, **We** must receive premium for **Employee** Term Life Insurance Coverage for the six consecutive month period while the **Employee** is covered under the Special Provisions for Not Being in Active Status. All premium must be submitted to **Us** through the **Employer**.

YOUR OPTIONS

Basic Term Life Coverage:

If this coverage terminates, the **Employee** may exercise the rights under the Life Conversion Privilege described in this Certificate. If the **Employee** returns to an **Active Status**, he or she will be considered a new **Employee** and must re-enroll for **Employee** Coverage.

EMPLOYEE TERM LIFE INSURANCE BENEFITS

BENEFIT

The amount of the **Employee** Term Life Insurance benefit is shown on the Schedule of Benefits. Subject to the terms below, a payment in this amount will be made to the beneficiary named by the **Employee**. Payment is made no later than two months after the date **We** receive proof the **Employee's** death, and the death occurred while insured for this benefit. The **Employee** Group Term Life Insurance has no cash surrender or loan values.

REDUCTION FOR AGE

Reduction percentage(s) and reduction age(s), if any, are shown on the Schedule of Benefits. If the **Employee's** death occurs on or after a reduction age, the amount of payment will be reduced by the corresponding reduction percentage shown. A reduction in benefits due to age is effective on the first day of the calendar month following the date the **Employee** attains that age.

BENEFICIARY

The **Employee** may name any beneficiary he or she chooses. The **Employee** may also change a named beneficiary at any time by notifying **Us** in writing. The change will be effective on the date the **Employee** signs the form. If **We** make a payment before receiving the change form, **We** are released from further liability to the extent of the payment.

If a payment is to be made to two or more beneficiaries, but the **Employee** has not specified the portions payable to each, the payment will be shared equally. If the **Employee** has not named a beneficiary, or if the beneficiary he or she named is not alive at the **Employee's** death, the payment will be made, at **Our** option, to any one or more of the following:

- **Your** spouse;
- **Your** children;
- **Your** parents;
- **Your** brothers and sisters; or
- **Your** estate.

We will rely upon an affidavit to determine benefit payment, unless **We** receive written notice of a valid claim before payment is made. Payment pursuant to the affidavit will release **Us** from further liability.

Any payment made by **Us** in good faith will fully discharge **Us** to the extent of such payment.

Any amount payable to a minor will be paid to the minor's legal guardian.

NOTICE OF DEATH

No payment will be made unless **We** receive written proof of **Your** death. If a death claim is filed while the Waiver of Premium is in effect, proof of continuous **Total Disability** must accompany the death claim.

EMPLOYEE LIFE INSURANCE CONVERSION PRIVILEGE

The **Employee** is entitled to apply for a Conversion Policy of Life Insurance if any portion of his or her Term Life Insurance Benefit terminates due to:

- Termination of employment or membership in a class eligible for Term Life Insurance. The amount the **Employee** is entitled to apply for is the amount of Term Life Insurance that is terminating, LESS the amount of Term Life Insurance for which he or she becomes eligible under any group coverage within 31 days after such termination; or

- Reduction for Age. The amount the **Employee** is entitled to apply for is the amount of insurance lost due to the reduction, but not more than $10,000.

If the **Employee's** Term Life Insurance benefit terminates because this coverage terminates, or is amended so as to terminate the eligible class to which the **Employee** belongs, and his or her **Employee** Term Life Insurance has been in effect under the Policy for at least three years, the amount the **Employee** is entitled to apply for is the lesser of:

- The amount of **Employee** Term Life Insurance that is terminating, LESS the amount of any Life Insurance for which he or she becomes eligible under any group coverage within 31 days after such termination; or

- $10,000.

CONVERSION POLICY

The Conversion Policy is issued without evidence of insurability. The **Employee** must apply for and pay the first premium within 31 days of the termination of the **Employee's** coverage under the Group Plan. The Conversion Policy will be effective on the 32nd day following such termination. The Conversion Policy will not include any Short Term Disability or Accidental Death or **Bodily Injury** benefits. It will be issued on any one of the Policy forms, except term insurance, then being issued by **Us** to individuals of the same age. Premiums for the Conversion Policy will be based on **Our** current rate for the form, amount of insurance and the **Employee's** age on the date of issue of the Conversion Policy.

DEATH DURING CONVERSION PERIOD

If the **Employee** dies during the 31 day period that he or she could have applied for a Conversion Policy, the amount of Life Insurance the **Employee** could have converted will be paid as the death benefit, even if the **Employee** had not applied for the Conversion Policy.

WAIVER OF PREMIUM

If the **Employee** becomes **Totally Disabled** while insured for this **Employee** Term Life Insurance Benefit, **We** will continue the **Employee's** Term Life Insurance Benefit during his or her **Total Disability** without the requirement of premium payment subject to the Waiver of Premium provision. In order for **Us** to approve Waiver of Premium, the **Employee** must:

- Become **Totally Disabled** before age 60;
- Remain **Totally Disabled** throughout the 180 consecutive day Elimination Period;
  Elimination Period means a period of continuous disability which must be satisfied before **You** are eligible to have **Your** life premium waived by **Us**.
- Request an application for Waiver of Premium and submit such application with proof of **Total Disability**, acceptable to **Us**, no later than 12 consecutive months after the **Employee** first became **Totally Disabled**.

Premium payment must continue until **We** approve the application for Waiver of Premium. Failure to do so will result in forfeiture of **Your** rights to Waiver of Premium.

The Waiver of Premium benefit begins at the end of the Elimination Period.

If the **Employee** dies prior to submitting the initial proof of **Total Disability** as required, proof that the **Total Disability** continued until the date of the **Employee's** death must be given to **Us** no later than 12 months following the **Employee's** death.

We will not approve an application for Waiver of Premium if the **Employee** becomes **Totally Disabled** after the **Employer** terminates coverage under the Policy.

EFFECT OF WAIVER OF PREMIUM

When **We** approve Waiver of Premium, no premium payment will be required for the **Employee's** Term Life Insurance benefit during his or her **Total Disability**. Proof of the **Total Disability** must be received by **Us** within one year from the date the **Total Disability** began.

The **Employee** is required to submit proof of continued **Total Disability** to **Us** three months before each anniversary date of the disability. **We** have the right to have the **Employee** examined for the **Total Disability** at any reasonable time during the first two years he or she is **Totally Disabled**. After that, **We** may have the **Employee** examined only once a year.

AMOUNT CONTINUED

The amount of the **Employee** Term Life Insurance benefit which will be continued under this Waiver of Premium is the amount that was in effect for the **Employee** on the date the **Total Disability** began. This amount will be reduced by the same amount, on the same dates, and for the same reasons that it would have been reduced if the **Employee** had not become **Totally Disabled**.

TERMINATION OF WAIVER OF PREMIUM

The Waiver of Premium terminates on the earliest of:

- The date the **Employee** fails or refuses to furnish proof of **Total Disability** as required;
- The date the **Employee** fails or refuses to be examined as required;
- The date the **Employee** is no longer **Totally Disabled**; or
- The **Employee's** 65th birthday.

If the Waiver of Premium benefit terminates and the **Employee** returns to an **Active Status**, he or she will be insured for the **Employee** Term Life Insurance benefit for which he or she is then eligible. Premium payment will be required for the **Employee** Term Life Insurance benefit.

If this Waiver of Premium terminates because the **Employee** is no longer **Totally Disabled** or attains age 65, and does not return to an **Active Status**, he or she may apply for a Conversion Policy of Life Insurance according to the Conversion Privilege provision in this Certificate.

Termination of the **Employer's** participation under the Policy WILL NOT terminate the **Employee's** Waiver of Premium. If the Waiver of Premium terminates after the **Employer's** participation under the Policy terminates, and if the **Employee** Term Life Insurance Benefit has been in force for at least three years, the **Employee** may apply for a Conversion Policy. The amount of any Conversion Policy is limited to the lesser of:

- The amount of **Employee** Term Life Insurance that is terminating LESS the amount of any Life Insurance for which the **Employee** becomes eligible under any group coverage within 31 days after such termination; or
- $10,000.

ACCIDENTAL DEATH OR BODILY INJURY BENEFIT FOR COVERED EMPLOYEES

Subject to the terms below, a benefit is payable for loss due to the **Employee's** Accidental Death or Accidental **Bodily Injury** if shown on the Schedule of Benefits. The loss must: (a) occur within 180 days after the accident which caused the loss; and (b) be due to an accident which occurs while the **Employee** is insured under the Benefit. If the **Employee** suffers multiple losses in the same accident, **Our** liability will be limited to payment for the one type of loss which provides the greatest benefit. The amount of benefit payable for each type of loss is:

LOSS OF LIFE OR DISMEMBERMENT BENEFIT	BENEFIT OTHER THAN A COMMON CARRIER ACCIDENT	BENEFIT FOR COMMON CARRIER ACCIDENT
Loss of Life	Full Amount	2 Times Full Amount
Loss of both hands	Full Amount	2 Times Full Amount
Loss of both feet	Full Amount	2 Times Full Amount
Loss of sight of both eyes	Full Amount	2 Times Full Amount
Loss of one hand and one foot	Full Amount	2 Times Full Amount
Loss of one hand or one foot and sight of one eye	Full Amount	2 Times Full Amount
Loss of one hand	One-Half of the Full Amount	Full Amount
Loss of one foot	One-Half of the Full Amount	Full Amount
Loss of sight of one eye	One-Half of the Full Amount	Full Amount
Loss of thumb and index finger of the same hand	One-Fourth of the Full Amount	One-Half of the Full Amount

PARALYSIS BENEFIT

The paralysis must be determined by a **Qualified Practitioner** to be permanent, complete and irreversible.

	BENEFIT OTHER THAN A COMMON CARRIER ACCIDENT	BENEFIT FOR COMMON CARRIER ACCIDENT
Quadriplegia	Full Amount	2 Times Full Amount
Paraplegia	One-Half of the Full Amount	Full Amount
Hemiplegia	One-Half of the Full Amount	Full Amount

REDUCTION FOR AGE

Reduction percentage(s) and reduction age(s), if applicable, are also shown on the Schedule of Benefits. If the **Employee's** loss occurs on or after a reduction age is effective, the full amount shown on the Schedule of Benefits will be reduced by the corresponding reduction percentage shown. This means that if the accident occurs before the effective date of the reduction age, but the **Employee's** loss occurs on or after the effective date of the reduction age, **We** will pay the benefit based on the reduced amount. A reduction age is effective on the first day of a calendar month following the date the **Employee** attains that age.

TO WHOM PAYABLE

Benefits for Accidental Dismemberment, or Paralysis are payable to the **Employee**. Benefits for Accidental Death are payable in accordance with the Employee Term Life Insurance Benefits provision - Beneficiary section.

DEFINITIONS

- ACCIDENTAL DEATH

Accidental Death means loss of life which results directly from:

- **Bodily Injury**;
- Infection caused by **Bodily Injury**, or infection resulting from accidental ingestion of contaminated substances; or
- Accidental drowning.

- ACCIDENTAL DISMEMBERMENT

Accidental Dismemberment means complete, permanent and irretrievable loss, resulting directly from **Bodily Injury** of:

- A hand or foot by severance at or above the wrist or ankle joint; or
- The sight of an eye.

- COMMON CARRIER ACCIDENT

Common Carrier Accident means a covered accidental Bodily Injury that is sustained while riding as a fare-paying passenger (not a pilot, operator or crew member) in or on, boarding or getting off from a common carrier.

- COMMON CARRIER

Common Carrier means any land, air or water vehicle operated under a valid license to transport passengers for hire.

- QUADRIPLEGIA

Quadriplegia means total paralysis of all four limbs.

- PARAPLEGIA

Paraplegia means total paralysis of both lower limbs.

- HEMIPLEGIA

Hemiplegia means total paralysis of one arm and one leg on the same side of the body.

REPATRIATION BENEFIT

We will pay a Repatriation Benefit if:

1. The **Employee** dies as a result of a accidental death at least 150 miles from his or her principal place of residence; and

2. Expense is incurred for preparing the **Employee's** body and transporting the **Employee's** body to a mortuary.

This benefit will be in addition to all other benefits payable under this Certificate. This benefit will equal the expenses incurred for preparing and transporting the **Employee's** body to a mortuary, subject to the maximum of $5,000. This benefit will be paid the date both proof of accidental loss of life and proof of expense incurred for preparing and transporting the body is received.

PROOF FOR REPATRIATION BENEFIT

For this benefit to be payable, proof of payment for any expense incurred for repatriation must be provided to **Us**.

TO WHOM PAYABLE FOR REPATRIATION BENEFIT

Benefits for repatriation will be paid in accordance with the Beneficiary Section of this Certificate. Benefits will not be payable for any loss excluded under the Accidental Death or Bodily Injury for covered Employees Limitations section.

ACCIDENTAL DEATH OR BODILY INJURY BENEFIT FOR COVERED EMPLOYEES (continued)

EDUCATION BENEFIT

We will pay an Education Benefit for each of the **Employee's** eligible **Dependent** children if the **Employee**:

- Is injured in a covered accident while insured under this Certificate;
- Dies as a direct result of these injuries within 365 days after the accident; and
- Is survived by one or more **Dependent** children who are eligible for the benefit.

To be eligible for the Education Benefit, a **Dependent** Child:

- Must be **Dependent** on the **Employee** for principal support;
- Must be enrolled as a full-time student on the date of the **Employee's** death or within 365 days after the date of death; and
- Must incur expenses after the date of the **Employee's** death for tuition, fees, books, room and board, approved or certified by that school, paid by the student or payable directly to that school.

This benefit will be paid in addition to all other benefits payable under this Certificate. The benefit will equal the actual expense incurred after the date of the **Employee's** death up to 5% of the **Employee's** death benefit, subject to a maximum of $5,000 for each eligible **Dependent** child per year, for up to four (4) consecutive years or until age 25 if all eligibility requirements are met for each payment. This benefit will be paid to the **Dependent** child if the child has reached the age of majority. Otherwise, benefits will be paid to the child's legal guardian. The first payment will be paid, the date both proof of accidental loss of life and proof of Educational expenses and that the Dependent child meets the above requirements is received.

Subsequent payments will be made when **We** receive:

- Verification that the eligible **Dependent** child continues to be a full-time student and meets the requirements of this benefit during each additional semester/year; and
- Proof of payment for the expenses incurred.

"Full-time student" means a **Dependent** child who:

- Is attending a licensed or accredited college, university or vocational school beyond the 12th grade;
- Is considered a full-time student based upon that school's standards; and
- Incurs expenses for tuition, fees, books, room and board, or other costs approved or certified by that school, paid by the student or payable directly to that school.

SPOUSE TRAINING BENEFIT

A Spouse Training Benefit will be paid to the **Employee's** lawful recognize spouse, if the **Employee**:

- Dies as a direct result of an Accidental Death; and
- Is survived by a spouse who is eligible for the benefit.

To be eligible for the Spouse Training Benefit, the **Employee's** spouse:

- Must be the lawfully recognized spouse of the **Employee** on the date of the accident;
- Must be enrolled as a student on the date of the **Employee's** death or within 365 days after that date of the **Employee's** death in a accredited school; and
- Must incur expenses after the date of the **Employee's** death for tuition, fees, books, room and board or other costs approved or certified by the school, paid by the student or payable directly to that school.

This benefit will be paid in addition to all other benefits payable under this Certificate. The benefit will equal the actual expense incurred after the date of the **Employee's** death up to 5% of the **Employee's** benefit, subject to a maximum of $5,000. This benefit will be paid for one year after the **Employee's** death. Payment will be made the date both proof of accidental loss of life and proof of expense incurred for Spousal Training and the spouse meets the above requirement is received.

EXCLUSIONS FOR SPOUSE TRAINING BENEFIT

Benefits will not be payable for any loss excluded under the Accidental Death or Bodily Injury Benefit for Covered Employees Limitation section.

CHILD CARE BENEFIT

A Child Care Benefit will be paid for each of the **Employee's** eligible **Dependent** children if the **Employee:**

- Is injured in a covered accident while insured under this Certificate;
- Dies as a direct result of these injuries within 365 days after the accident; and
- Is survived by one or more **Dependent** children who are eligible for the benefit.

To be eligible for the Child Care Benefit, a **Dependent** child must:

- Meet all the qualifications of a **Dependent** as determined by the Internal Revenue Service;
- Be declared on and legally qualify as a **Dependent** on the **Employee's** Federal personal income tax return filed for each year the benefits are request under the Child Care Benefit;
- Be under age 13 on the date of the accident; and
- Attends a licensed Child Care Center, once a week or on a more frequent basis, on the date of the **Employee's** death or within 365 days after that date.

The Child Care Benefit is paid in addition to all other Certificate benefits. The benefit will equal the actual expense incurred after the date of the **Employee's** death, up to 5% of the **Employee's** benefit, subject to a maximum of $5,000 for each eligible **Dependent** child per year. The benefit will be paid to the legal guardian of the eligible **Dependent** child the earliest of the following:

- For up to four (4) consecutive years; or
- Until the **Dependent** child's 13th birthday.

The first payment will be made the date proof of accidental loss of life and proof of expenses incurred for Child Care and that the eligible **Dependent** child meets the above requirements is received.

Subsequent payment will be made on a reimbursement basis when **We** receive:

- Verification that the eligible **Dependent** child continues to attend a licensed Child Care Center on a regular basis; and
- Satisfactory proof of payment for the childcare expense incurred.

DEFINITIONS

- CHILD CARE CENTER

Child Care Center means any facility, other than a family day care home that:

- Is licensed as a Child Care Center by the state in which it is physically located, and where the **Dependent** child physically attends; and
- Provides non-medical care and supervision for children in a group setting; and
- Cares for children at least six (6) but less than 24 hours per day.

EXPENSE INCURRED

Expense incurred means the cost for the supervision and care of a Dependent child, excluding any fees for extra activities that are directly payable to a Child Care Center.

EXCLUSIONS FOR CHILD CARE BENEFIT

Benefits will not be paid:

- When the **Dependent** Child's care is provided by, or at a facility operated by the child's grandparent, parent, aunt, uncle, or sibling; or
- For any loss excluded under the Accidental Death or Bodily Injury for Covered Employees Limitation section of this Certificate.

COMA BENEFIT

Coma means being in a state of complete mental and physical unresponsiveness in which neither arousal nor awareness is present and there is no evidence of appropriate responses to stimulation.

We will pay a Coma Benefit when the Employee remains in a Coma if:

- The Coma is caused by a **Bodily Injury** sustained while insured under this Certificate;
- The Coma begins within 365 days after the date of the accident; and
- The person remains in a Coma for more than 31 consecutive days.

The Coma must result directly from the **Bodily Injury** and from no other causes.

ACCIDENTAL DEATH OR BODILY INJURY BENEFIT FOR COVERED EMPLOYEES (continued)

The benefit will be paid in addition to all other benefits payable under this Certificate. The Coma Benefit will equal a one time payment of 5% of the **Employee's** benefit, subject to a maximum of $5,000.

PROOF FOR COMA BENEFIT

Proof of the Coma must be provided to **Us**. **We** retain the right to investigate and to determine whether the coma exists.

TO WHOM PAYABLE FOR COMA BENEFIT

Upon receipt of satisfactory proof, the Coma Benefit will be paid to the **Employee.**

EXCLUSIONS FOR COMA BENEFIT

Benefits will not be paid:

- When the **Employee** remains in a coma for less than 31 consecutive days; or
- For any loss excluded under the Accidental Death or Bodily Injury for Covered Employees Limitation section of this Certificate.

SEAT BELT - AIRBAG - HELMET BENEFIT

The Seat Belt, Airbag, Helmet Benefit is payable if **You** die as a direct result of **Bodily Injury** sustained in an automobile or motorcycle accident as a passenger or driver.

In the event of an automobile accident the benefit is payable if:

- A copy of the police report is submitted with the claim;
- **You** were seated in a seat equipped with a properly functioning air bag;
- **You** were wearing a properly fastened seat belt in the correct position; and
- The correct position of the seat belt was certified by the investigating officer or indicated in the police report.

We will increase **Your** Accidental Death benefit by 10%, up to $10,000, but not less than $1,000 for using **Your** seat belt. Additionally, **We** will increase **Your** Accidental Death benefit by 5%, up to $5,000, but no less than $500 for the properly functioning airbag.

In the event of a motorcycle accident the benefit is payable if:

- A copy of the police report is submitted with the claim;
- **You** were wearing a properly fitted and fastened motorcycle helmet; and
- The use of properly fitted and fastened motorcycle helmet was certified by the investigating officer or indicated in the police report.

We will increase **Your** Accidental Death benefit by 10%, up to $10,000, but not less than $1,000 for wearing a properly fitted and fastened motorcycle helmet.

ACCIDENTAL DEATH OR BODILY INJURY BENEFIT FOR COVERED EMPLOYEES (continued)

If **We** are unable to determine whether **You** had been wearing a properly fastened seat belt, seated in a seat equipped with a functioning airbag, or wearing a properly fitted and fastened motorcycle helmet. **We** will pay a benefit of $1,000 to **Your** beneficiary.

DEFINITIONS

- AUTO

Auto means a four-wheel passenger car, station wagon, sport utility vehicle, truck or van-type car. It must be licensed for use on public highways. It includes a car owned or leased by a group certificate holder.

- MOTOR CYCLE

Motor Cycle means a two wheel passenger motorcycle. It must be licensed for use on public highways. It includes a motorcycle owned or leased by a group certificate holder.

LIMITATIONS

Accidental Death or **Bodily Injury** benefits DO NOT cover loss resulting from:

- Self-induced **Sickness**, attempted suicide or intentionally self-inflicted **Bodily Injury**, whether sane or insane;
- The voluntary taking of any sedative, drug, alcohol, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a **Qualified Practitioner**;
- Being intoxicated or under the influence of any unlawful substance, narcotic or hallucinogenic, unless administered on the advice of a **Qualified Practitioner**;
- Travel or flight in a device of any type for aerial navigation, except as a fare-paying passenger of a licensed passenger airline;
- Commission or attempt to commit a civil or criminal battery or felony;
- Driving or operating a motorized vehicle while legally intoxicated or under the influence of illegal substance. Intoxication means that blood alcohol content or the results of other means of testing blood alcohol level meet or exceeds the legal presumption of intoxication under the law of the state where the accident took place;
- Driving or operating a motorized vehicle without a valid drivers' license;
- Driving or operating a motorized vehicle in excess of the legal speed limit;
- Service in any armed forces, except if **You** are in temporary active duty as a reservist for military training that lasts 30 days or less;

ACCIDENTAL DEATH OR BODILY INJURY BENEFIT FOR COVERED EMPLOYEES (continued)

- **Bodily Injury** or **Sickness** contributed to or caused by:

  - War or any act of war, whether declared or not; or
  - Any act of armed conflict, or any conflict involving armed forces of any authority;

- Bodily or mental infirmity, or its related surgical or medical treatment or any infection unless the direct result of **Bodily Injury**, or unless resulting from the accidental ingestion of a contaminated substance;

- Participation in a riot, rebellion or insurrection. Participation means taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without the authority of law; or

- Participation in hazardous sports, including but not limited to: bungee jumping, motorized vehicle racing, rock climbing, rodeo events, scuba diving, skydiving, parachuting, hang gliding, or ballooning.

ACCELERATED DEATH BENEFITS

If a covered **Employee** is diagnosed with a Qualifying Condition, the **Employee** may request that an accelerated benefit be paid immediately. The amount payable is 50% to a maximum benefit of $250,000.

DEATH BENEFITS WILL BE REDUCED IF AN ACCELERATED BENEFIT IS PAID.

DEFINITIONS

Activities of Daily Living mean Bathing, Maintaining Continence, Dressing, Eating, Toileting and Transferring.

Adult Day Care means a social and health-related services program provided during the day in a community group setting, for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Facility means a provider of Adult Day Care services operated pursuant to the provisions of the Human Resources Code, Chapter 103 (concerning licensing and quality of care requirements in the provision of adult day care).

Bathing means washing yourself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating means feeding yourself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Home Health Agency means a business which provides home health service and is licensed by the Texas Department of Health under Texas Civil Statutes, Article 4447u.

Home Health Care Services mean medical or nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, respite care services, case management services, and maintenance or personal care services.

Long Term Care Illness means the **Employee**:

- Is unable to perform at least two Activities of Daily Living; or
- Has an impairment of cognitive ability. Impairment of cognitive ability means the deterioration or loss in intellectual capacity requiring substantial supervision for protection of self and others, as established by the clinical diagnosis of any **Qualified Practitioner** in the state of Texas authorized to make such a diagnosis. Such diagnosis shall include the patient's history and physical, neurological, psychological and/or psychiatric evaluations and laboratory findings.

Maintaining Continence means the ability to maintain control of bowel and bladder function or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including care for catheter or colostomy bag).

Qualifying Condition means:

- Long-Term Care Illness;
- Specified Disease; or
- Terminal Illness.

Specified Disease means a **Sickness** or **Bodily Injury** that is likely to cause permanent disability or premature death including, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- Malignant tumor;
- A condition that requires an organ transplant;
- Coronary artery disease resulting in acute infarction or requiring surgery; or
- Permanent neurological deficit resulting from cerebral vascular accident.

Terminal Illness means a **Sickness** or **Bodily Injury** which is diagnosed by a **Qualified Practitioner** as life-threatening with a life expectancy of 24 months or less.

Toileting means getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

Transferring means sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either by way of walking, a wheelchair or other means.

QUALIFICATIONS FOR ACCELERATED BENEFITS

Payment of this benefit does not guarantee that the **Employee's** full death benefit will eventually be paid. The **Employee** must still be insured under the Policy at the time of death for the remainder of the Term Life Insurance benefit to be paid.

To qualify for the Accelerated Death Benefit the covered **Employee** must:

- Be covered under the Policy a minimum of 6 months;
- Provide proof of Qualifying Condition acceptable to **Us**; and
- Request this benefit in writing on a form acceptable by **Us**.

PROOF OF QUALIFYING CONDITIONS

A **Qualified Practitioner's** written certification is required as proof that a Qualifying Condition exists. **We** reserve the right to request any additional medical information **We** believe necessary to confirm the **Employee's** Qualifying Condition. **We** also reserve the right to request a second opinion from a **Qualified Practitioner** appointed by **Us**. The second opinion would be paid by **Us**. If **You** fail to submit proof satisfactory to **Us** that **You** have a Qualifying Condition, or refuse to be examined as may be required by **Us**, no Accelerated Benefit will be payable.

In the event that **Your Qualified Practitioner** and a **Qualified Practitioner** appointed by **Us** are unable to agree that a Qualifying Condition has occurred, the opinion of the **Qualified Practitioner** appointed by **Us** will prevail.

QUALIFIED TREATMENT FACILITY OF LONG TERM CARE ILLNESS

Qualified Treatment Facility of Long Term Care Illness includes, but is not limited to, a convalescent nursing home, residential care or intermediate nursing facility, which is operated pursuant to state and federal law.

Qualified Treatment Facility of Long Term Care Illness does not include:

- Any home, facility or part thereof used primarily for rest;
- A home or facility for:

  - The aged;
  - Drug addicts or Alcoholics;
  - The care and treatment of mental diseases or disorder;
  - Custodial care; or
  - Educational care.

EXCLUSIONS

- Accelerated Benefits are not available for a Qualifying Condition which resulted from a self-induced **Sickness**, attempted suicide or intentionally self-inflicted **Bodily Injury**, whether sane or insane; or
- Accelerated Benefits are not payable to an **Employee** who is:

  - Required by law to use this benefit to satisfy claims of creditors; or
  - Required by a government agency to use this benefit to apply for, obtain or keep a government benefit or entitlement.

BENEFITS PAYABLE

Payment will be made in one lump sum to **You** and is payable once during **Your** lifetime. The amount requested must be at least $5,000.

Notice: At the time of payment of this benefit, We will send You or the owner, whichever is applicable, a statement specifying the amount of benefits paid and the effect of the benefit payment on Your Term Life Insurance amount.

If the amount of **Your** Term Life Insurance is scheduled to reduce within 6 months following the date **You** apply for the Accelerated Benefit, **Your** benefit payable will be based on the reduced amount.

Payment from this benefit may be taxable. Assistance should be sought from **Your** personal tax advisor. **We** are not responsible for any tax or other effects of an accelerated benefit payment or loss of eligibility for any State or Federal program.

EFFECT ON EMPLOYEE TERM LIFE INSURANCE BENEFIT

The amount of Term Life Insurance payable to the beneficiary at the time of death will be reduced by any accelerated benefit amount paid. The remaining Term Life Insurance amount will be paid according to the terms and provisions of the Policy. Any amount **You** could otherwise convert will also be reduced by the accelerated benefit.

GENERAL PROVISIONS

NOTICE OF CLAIM

Written notice of claim, other than claim for loss of life, must be given within 30 days after the date of loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice may be given at **Our** address and should include **Your** name and the name(s) of **Your Dependent(s)** and **Your** Group Number.

CLAIM FORMS

Upon receipt of notice of claim, **We** will send **You** the forms for filing proof of loss. If the forms are not sent to **You** within 15 days, **You** will have met the proof of loss requirement by sending **Us** a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS

You must give written proof of loss within 91 days after the date of loss, except for loss of life. **Your** claim will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written notice must be given within one year after the date proof of loss is otherwise required, except if **You** were legally incapacitated.

TIME OF PAYMENT OF CLAIMS

Payments due under the Policy will be paid upon receipt of written proof of loss.

CLAIM APPEAL PROCEDURE

If **We** partially or fully deny a claim for benefits submitted by **You**, and **You** disagree or do not understand the reasons for this denial, **You** may appeal this decision. **You** have the right to:

- Request a review of the denial;
- Review pertinent plan documents; and
- Submit in writing, any data, documents or comments which are relevant to Our review of this denial.

Your appeal must be submitted in writing within 60 days of receiving written notice of denial. **We** will review all information and send written notification within 60 days of **Your** request.

INCONTESTABILITY

After **You** are insured without interruption for two years, **We** cannot contest the validity of **Your** coverage except for nonpayment of premium. The incontestability period begins with **Your** effective date as stated on the cover page of this Certificate.

An independent incontestability period begins for each type of increase in coverage. The new incontestability period will only apply to the increased coverage.

No statement made by **You** can be contested unless it is in a written form signed by **You.** A copy of the form must be given to **You** or **Your** beneficiary.

FRAUD

If **You** intentionally commit fraud against **Us** or **Your Employer** commits fraud pertaining to **You** against **Us** or **You** or **Your Employer** misrepresent material information to **Us** as determined by a court of competent jurisdiction, **Your** coverage ends automatically, subject to the Incontestability clause under this Policy.

TIME LIMIT ON CERTAIN DEFENSES

A claim will not be reduced or denied after two years from the effective date of the benefit because a disease or physical condition not excluded and causing the loss existed before the benefit effective date.

CLERICAL ERROR, MISSTATEMENT OF AGE OR GENDER

If it is determined that information about the age or gender of **You** or **Your Dependents** was omitted or misstated in error, the amount of insurance for which **You** are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to **You** and to **Us**.

DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, **We** will pay only under the provision allowing the greater benefits. This may require **Us** to make a recalculation based upon both the amounts already paid and the amounts due to be paid. **We** have NO liability for benefits other than those the Policy provides.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

RIGHT TO REQUEST OVERPAYMENTS

We reserve the right to recover any payments made by **Us** that were made in error.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with **Us** and when asked, assist **Us** by:

- Authorizing the release of medical information including the names of all providers from whom **You** received medical attention;
- Obtaining medical information and/or records from any provider as requested by **Us**;
- Providing information regarding the circumstances of **Your** injury or accident;
- Providing information about other insurance coverage and benefits; and
- Providing information **We** request to administer the Policy.

PHYSICAL EXAMINATION AND AUTOPSY

We, at **Our** expense, have the right to have **You** examined as often as **We** deem reasonably necessary, but no more frequently than every three months. **We** may also have an autopsy performed unless prohibited by law.

LEGAL ACTIONS

You cannot bring an action at law or equity to recover a claim until 60 days after the date written proof of loss is made. **You** cannot bring such action more than two years after such proof of loss is made.

ASSIGNMENT OF BENEFITS FOR LIFE COVERAGE

Except for the dismemberment benefits under the Accidental Death and Bodily Injury Benefit for Covered Employees. **You** have the right to absolutely assign all of **Your** rights and interest under the Policy including, but not limited to, the following:

- The right to make any contributions required to keep the insurance in force;
- The privilege of converting; and
- The right to name and change a beneficiary.

If an Irrevocable beneficiary has been designated, Assignment of Benefit will not be allowed.

No absolute assignment of rights and interest shall be binding on **Us** until and unless the original or certified copy of the form documenting the absolute assignment is received and acknowledge by **Us** at our office.

WORKER'S COMPENSATION

If benefits are paid by **Us** and **We** determine **You** received Workers' Compensation for the same incident, **We** have the right to recover as described under the "Recovery Rights" provision. **We** will exercise **Our** right to recover against **You**.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- NO final determination is made that **Bodily Injury** or **Sickness** was sustained in the course of or resulted from **Your** employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by **You** or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Policy, **You** will notify **Us** of any Workers' Compensation claim **You** make, and that **You** agree to reimburse **Us** as described above.

MODIFICATION OF POLICY

The Policy may be modified at any time by agreement between **Us** and the **Policyholder** without the consent of any **Covered Person** or any beneficiary. No modification will be valid unless approved by **Our** President or Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy, or waive any of the Policy provisions, to extend the time of premium payment, or bind **Us** by making any promise or representation.

PREMIUM CONTRIBUTIONS

Your Employer must pay the required premium to **Us** as they become due. **Your Employer** may require **You** to contribute toward the cost of **Your** insurance. Failure of **Your Employer** to pay any required premium to **Us** on time will result in the termination of **Your** insurance.

GRACE PERIOD

A grace period of 31 days will be allowed for payment of each premium due. If premium due is not paid within the grace period, **We** will cancel the insurance at the end of the grace period. All due and unpaid premium, including premium for the grace period, must be paid to **Us** by **Your Employer**.

Humana.

Toll Free: 800-558-4444
1100 Employers Blvd.
Green Bay, WI 54344
www.humana.com

INSURED BY
HUMANA INSURANCE COMPANY

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
515 Congress Avenue, Suite 1875
Austin, TX 78701
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
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). These protections apply to insolvencies that occur on or after September 1, 2019. **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.

Notices

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

- **Claims Procedures**
- **Appeals of Adverse Determinations**
- **Your Rights Under ERISA**

Privacy and Confidentiality Statement

Discrimination Notice

LIFE INSURANCE WAVIER OF PREMIUM AND SHORT TERM DISABILITY CLAIMS PROCEDURES

CLAIMS PROCEDURES

Definitions
Humana: Humana Insurance Company
Claimant: A covered person (or authorized representative) who files a claim.

Submitting a Claim

This section describes how a Claimant files a claim for plan benefits.

A request for a waiver of Life Insurance premium due to a total disability will be treated as a claim.

A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be submitted on the claims form provided by Humana and available from your employer. The claim form must be complete.

Authorized Representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims Decisions

Humana will provide notice of a favorable or adverse determination within a reasonable time but no later than 45 days after the plan receives the claim.

This period may be extended an additional 30 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 45-day period, Humana will notify the affected Claimant of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

The review period may be extended for another 30 days, if before the end of the first 30-day extension, the plan determines a second extension is necessary due to matters beyond the plan's control. Before the end of the first 30-day extension, Humana will notify the affected Claimant of the additional extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the Claimant responds or the expiration of the time allowed for submission of the requested information.

Initial Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above.

A claims denial notice will convey the specific reason for the adverse determination and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to Claimants, free of charge, upon request.

APPEALS OF ADVERSE DETERMINATIONS

A Claimant must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a Claimant by means of written application to Humana, in person, or by mail, postage prepaid.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person.

On appeal, a Claimant may review pertinent documents and may submit issues and comments in writing. A Claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time Periods for Decisions on Appeal

Appeals of claims denials will be decided and notice provided within 45 days after Humana receives the appeal request.

This period may be extended an additional 45 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 45-day period, Humana will notify the affected Claimant of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

Appeals Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provision upon which the determination is based.
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the Claimant, free of charge, upon request.
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the Claimant's right to bring an action under ERISA.

In the event an appealed claim is denied, the Claimant, will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination.
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination.
- Demonstrates compliance with the administrative processes and safeguards required in making the determination.
- Constitutes a statement of plan policy or guidance with respect to the plan concerning the denied benefit, without regard to whether the statement was relied on in making the benefit determination.

EXHAUSTION OF REMEDIES

Upon completion of the appeals process under this section, a Claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the Claimant may proceed to the next level in the review process.

After exhaustion of remedies, a Claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

LEGAL ACTIONS AND LIMITATIONS

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

YOUR RIGHTS UNDER ERISA

Under the Employee Retirement Income Security Act of 1974 (ERISA), all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the Plan and Benefits

Plan participants may:

1. Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office.
2. Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator.
3. Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called 'fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Claims Determinations

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

Enforce Your Rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance, if a participant requests a copy of plan documents does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $ 110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court. In addition, if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court. If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with Questions

Contact the group health plan human resources department or the plan administrator with questions about the plan. Contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 with questions about ERISA rights. Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

PRIVACY AND CONFIDENTIALITY STATEMENT

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose you PHI, without your consent/authorization, in the following ways:

Treatment: we may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.

Payment: we may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.

Important! _____

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **877-320-1235** or if you use a **TTY**, call **711**.

- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)
Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ nikáadoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0721