Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid

HOSPITAL CARE COVERAGE

SUMMARY OF BENEFITS

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Hospital Care coverage provides a benefit according to the schedule below when a Covered Person incurs a Hospital stay resulting from a Covered Injury or Covered Illness. *See State Variations (marked by *) below.*

Who Can Elect Coverage:

You: All active Employees of the Employer regularly working a minimum of 20 hours per week, who are United States citizens or permanent resident aliens, regularly working and residing in the United States and their U.S. citizen Spouse and Dependent Children who are residing in the United States. You will be eligible for coverage immediately.

Your Spouse/Domestic Partner: Up to age 99, as long as you apply for and are approved for coverage yourself.

Your Child(ren): Birth to 26; 26+ if disabled, as long as you apply for and are approved for coverage yourself.

Available Coverage:

The benefit amounts shown in this summary will be paid regardless of the actual expenses incurred. Benefits are only payable when all policy terms and conditions are met. Please read all the information in this summary to understand the terms, conditions, state variations, exclusions and limitations applicable to these benefits. See your Certificate of Insurance for more information.

Benefit Waiting Period:* 0 days following the effective date, unless otherwise stated. No benefits will be paid for a loss which occurs during the Benefit Waiting Period.

Hospitalization Benefits	Plan 1
Hospital Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 90 days.	$1,000 per day
Hospital Chronic Condition Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 90 days.	$50 per day
Hospital Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 90 days.	$100 per day
Hospital Intensive Care Unit (ICU) Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 90 days.	$200 per day
Hospital Observation Stay 24 hour Elimination Period. Limited to 72 hours.	$100 per 24-hour period

Portability Feature:* You, your spouse, and child(ren) can continue 100% of your coverage at the time your coverage ends. You must be covered under the policy and be under the age of 99 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

Employee's Monthly Cost of Coverage:

Tier	Plan 1
Employee Only	$19.23
Employee & Spouse	$40.57
Employee & Child(ren)	$33.50
Employee & Family	$54.84

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.

NOTE: This insurance is NOT a substitute for comprehensive or major medical insurance coverage.

NOTE: The following are some of the important policy provisions, terms and conditions that apply to benefits described in the policy. This is not a complete list. See your Certificate of Insurance for more information.

Benefit Amounts Payable: Benefits for all Covered Persons are payable at 100% of the Benefit Amounts shown, unless otherwise stated. Late applicants, if allowed under this plan, may be required to provide medical evidence of insurability.

Benefit-Specific Conditions, Exclusions & Limitations (Hospital Care):

- **Hospital Admission:** Must be admitted as an Inpatient due to a Covered Injury or Covered Illness. Excludes: treatment in an emergency room, provided on an outpatient basis.
- **Hospital Chronic Condition Admission:** Must be admitted as an Inpatient due to a covered chronic condition and treatment for the covered chronic condition must be provided by a specialist in that field of medicine. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Injury or Covered Illness (including chronic conditions).
- **Hospital Stay:** Must be admitted as an Inpatient and confined to the Hospital, due to a Covered Injury or Covered Illness, at the direction and under the care of a physician. If also eligible for the ICU Stay Benefit, only 1 benefit(s) will be paid for the same Covered Injury or Covered Illness, whichever is greater. Hospital stays within 30 days for the same or a related Covered Injury or Covered Illness is considered one Hospital Stay.
- **Intensive Care Unit (ICU) Stay:** Must be admitted as an Inpatient and confined in an ICU of a Hospital, due to a Covered Injury or Covered Illness, at the direction and under the care of a physician. If also eligible for the Hospital Stay Benefit, only 1 benefit(s) will be paid for the same Covered Injury or Covered Illness, whichever is greater. ICU stays within 90 days for the same or a related Covered Injury or Covered Illness is considered one ICU stay.
- **Hospital Observation Stay:** Must be receiving treatment for a Covered Injury or Covered Illness in a Hospital, including an observation room, or ambulatory surgical center, for more than 24 hour on a non-inpatient basis and a charge must be incurred. This benefit is not payable if a benefit is payable under the Hospital Stay Benefit or Hospital Intensive Care Unit Stay Benefit.

Common Exclusions and Limitations:

Exclusions:* In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Illness which is caused by or results from any of the following (unless otherwise provided for in the policy):

- (1) intentionally self-inflicted injury, suicide or any attempted threat while sane or insane;
- (2) commission or attempt to commit a felony or an assault;
- (3) declared or undeclared war or act of war;
- (4) a Covered Injury or Covered Illness that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon our receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
- (5) voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage (excludes WA residents);
- (6) operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Injury or Covered Illness occurred. (excludes WA residents)
- Those not necessary, as determined by Us in accordance with generally accepted standards of medical practice, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed, recommended, or approved by the attending physician.
- Elective or cosmetic surgery. This does not include reconstructive, cosmetic surgery: a) incidental to or following surgery for trauma, infection or other disease of the involved part; or b) due to congenital disease or anomaly of a Covered Dependent child which has resulted in a functional defect.
- Dental surgery, unless the surgery is the result of an accidental injury;
- In addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
  - Employed or retained by the Subscriber;
  - providing homeopathic, aroma-therapeutic or herbal therapeutic services;
  - living in the Covered Person's household;
  - a parent, sibling, spouse or child of the Covered Person.

Pre-Existing Condition Limitation (applies to hospital care insurance only):* We will not pay benefits for a Covered Injury or Covered Illness caused, contributed to by, or resulting from, a Pre-Existing Condition. The term ''Pre-Existing Condition'' means any Illness or Injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a Physician within 6 months before the Covered Person's most recent effective date of insurance, and the most recent effective date of any added or increased amount of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Injury or Covered Illness that occurs after the Covered Person is insured under the Policy for at least 6 continuous months after the Covered Person's most recent effective date of insurance and effective date of any added or increased amount of coverage.

Important Definitions:

Covered Illness: A physical or mental disease or disorder including pregnancy and complications of pregnancy that results in a covered loss. A Covered Illness includes medically-necessary quarantine in a Hospital in conjunction with medically-necessary preventive treatment due to an identifiable exposure to a life-threatening contagious and infectious disease.

Covered Injury: Any bodily harm that results in a covered loss.

Important Definitions — continued

Covered Person: An eligible person, as defined in the Schedule of Benefits, who is enrolled and for whom Evidence of Insurability, where required, has been accepted by Us, required premium has been paid when due, and coverage under this Policy remains in force.

Elimination Period: The continuous period of time that must be satisfied before a benefit shown in the Schedule of Benefits is payable. An Elimination Period may be satisfied during the Policy's Benefit Waiting Period.

Hospital:* An institution that is licensed as a hospital pursuant to applicable law; primarily and continuously engaged in providing medical care and treatment to sick and injured persons; managed under the supervision of a staff of physicians; provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and has medical, diagnostic and treatment facilities with major surgical facilities on its premises, or available to it on a prearranged basis. The term Hospital does not include a clinic, facility, or unit of a Hospital for: (1) rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care; (2) the aged, drug addicts or alcoholics; or (3) a facility primarily or solely providing psychiatric services to mentally ill patients.

Policy Provisions:

When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, the first of the month following the date your completed enrollment form is received or if evidence of insurability is required, the first of the month after we have approved you (or your dependent) for coverage in writing unless otherwise agreed upon by Cigna. Your coverage will not begin unless you are actively at work on the effective date. Coverage for Covered Persons will not begin on the effective date if the covered person is confined to a hospital, facility or at home; disabled or receiving disability benefits or unable to perform activities of daily living.

When your coverage ends: Coverage for any Covered Person ends on the earliest of the date they are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your Spouse and Dependent Child(ren), if applicable, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the *Continuation of Insurance* provisions in your Certificate.)

30 Day Right To Examine Certificate: If a Covered Person is not satisfied with the Certificate for any reason, it may be returned to us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

***State Variations**

Spouse definition includes civil union for employees residing in Vermont. **Portability** in VT is referred to as Continuation due to loss of eligibility. VT residents are not subject to the age limit to continue coverage. **Pre-Existing Condition Limitation,** differs in CA, FL, NC, SC and SD. **Exclusions** may vary for residents of MN, SC, SD, and WA. **Important Definitions** (Hospital) includes stays in substance abuse and mental nervous facilities in VT.

Series 1.0/1.1

THIS POLICY PAYS LIMITED BENEFITS ONLY. IT DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT A MEDICAID OR MEDICARE SUPPLEMENT POLICY.

This is not intended as a complete description of the insurance coverage offered. This is not a contract. Full terms and conditions of coverage are defined by and governed by Group Policy No.HC 960313. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence. Product availability, costs, benefits, riders and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form GHIP-00-1000.00. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

Cigna
P.O. Box 55290
Phoenix, AZ 85078
1-800-754-3207 Toll Free
1-860-730-6460 Fax
E-mail Address*: Hospitalcare@cigna.com

Group Hospital (Care) Indemnity Insurance Benefits - Proof of Loss

Life Insurance Company of North America
Cigna Life Insurance Company of New York

*When transmitting communications, including documents, to this email address, please be sure to encrypt your message prior to sending. Cigna assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information.

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NEW YORK FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

CAUTION: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the last page of this form: ***California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia or Washington.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR HOSPITAL (CARE) INDEMNITY AND ACCIDENT INDEMNITY BENEFITS.

YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

To The Employee/Member: For all benefits, complete pages 2, 3, and 4 and review page 5.

SECTION TO BE COMPLETED BY THE EMPLOYEE/MEMBER OR EMPLOYEE/MEMBER AND DEPENDENT

Name of Employee/Member *(Last Name)* *(First Name)* *(Middle Initial)*	Date of Birth	Social Security No.	Sex ☐ M ☐ F

Address *(Street)* *(City)* *(State)* *(Zip Code)*

Employee's/Member's Marital Status

☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced ☐ Domestic Partner Relationship ☐ Civil Union

Telephone Numbers Day Evening	Email Address
Policy Number(s)	Occupation

Please check all of the boxes that apply to the employee's/member's employment status and job classification. Hrs./Wk. ____

☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried ☐ Full-time

☐ Retired ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time

Date Hired/Member of Assoc.	Date Last Worked	Date of Injury, Illness or Accident

Were you an Active Employee/Member until the date of Injury, Illness or Accident? ☐ Yes ☐ No If No, Please Explain

If you were not actively at work immediately prior to your injury/illness/accident or your Dependent's injury/illness/accident, what was the reason?

☐ Disability (STD/LTD) ☐ Unpaid Leave of Absence ☐ Temporary Layoff ☐ Discharged

☐ Paid Leave of Absence ☐ FMLA ☐ Vacation ☐ Resigned ☐ Other: _____

Do you have health care coverage with a Cigna HealthCare plan? ☐ Yes ☐ No

TO BE COMPLETED IF CLAIM IS FOR DEPENDENT BENEFITS

Name of Dependent *(Last Name)* *(First Name)* *(Middle Initial)*	Date of Birth	Social Security No.	Sex ☐ M ☐ F

Relationship to Employee/Member	Dependent's Occupation	Was the Dependent Disabled prior to the date of the injury or illness? ☐ Yes ☐ No	If Yes, Date Disability began

Telephone Numbers Day Evening	Dependent's Employer	Dependent's Employer's Telephone Number

EMPLOYER/ASSOCIATION INFORMATION

Name of Employer/Association	E-Mail Address

Address *(Street)* *(City)* *(State)* *(Zip Code)*	Telephone # ( )

CERTIFICATION

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. SIGNATURE OF EMPLOYEE/MEMBER OR AUTHORIZED REPRESENTATIVE:	Date Signed

The issuance of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights.

TO BE COMPLETED BY THE EMPLOYEE / MEMBER / DEPENDENT

Name of Employee/Member *(Last Name)*	*(First Name)*	*(Middle Initial)*	Social Security No.

Name of Dependent *(Last Name)*	*(First Name)*	*(Middle Initial)*

PLEASE DESCRIBE THE DETAILS REGARDING YOUR HOSPITALIZATION AND TREATMENT FOR YOUR INJURY OR ILLNESS.

DATE AND TIME OF INJURY, ILLNESS, OR ACCIDENT	WHAT DISEASES, ILLNESS, INJURIES OR ACCIDENTS DID THE INJURED PERSON HAVE DURING THE PAST 3 YEARS?

PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED THE ILL OR INJURED PERSON DURING THE PAST 3 YEARS

NAME	COMPLETE ADDRESS	PHONE NUMBER	TREATMENT PERIOD

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF EMPLOYEE/MEMBER:	DATE SIGNED

The issuance of this form is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

Disclosure Authorization

Claimant's Name: _____

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

If my employer, union, and/or group association sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

_____ _____

(Claimant's Signature) (Date Signed)

_____ _____

(Print Name) (Date of Birth)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Life Insurance Company of North America
Cigna Life Insurance Company of New York

IMPORTANT CLAIM NOTICE

California Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas Residents: Any person who knowingly and with intent to defraud any insurance company or other person (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, may be guilty of insurance fraud determined by a court of law.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon Residents: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

Washington Residents*:* It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.