UnitedHealthcare®

GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE OF COVERAGE

FOR BA, HOLDINGS, INC.

POLICY NUMBER: 371448

EFFECTIVE DATE: January 1, 2024

CA – UHIC/2017
(9-24)

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

(Home Office)

Policyholder: BA, Holdings, Inc.

Policyholder Effective Date: January 1, 2024

Policy Number: 371448

Policy Anniversary Date: January 1st

Beneficiary: As on file with the Administrator

We, UnitedHealthcare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy.

The Policy is a legal contract between the Policyholder and Us and it may be changed or discontinued without the consent of the Covered Person or the Covered Person's beneficiary. The Policy may be inspected at the office of the Policyholder.

The benefits described in this Certificate insure the Covered Person and, if applicable, Dependents, provided the person is eligible, has become covered, and the required premium has been paid to Us.

Read this Certificate Carefully. If the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, call 1-888-299-2070. If the Policyholder has any questions or problems with the Policy, the Policyholder may call upon Our Home Office for assistance at any time.

The Certificate is signed at the Home Office of UnitedHealthcare Insurance Company by:

Tracy A. Arney, Secretary Jessica Paik, President

Administrative Office:

9900 Bren Road East
Minnetonka, MN 55343

Group Hospital Indemnity Plan Only Certificate

THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE, A HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACT OR MAJOR MEDICAL EXPENSE INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL HEALTH LAW. FAILURE TO HAVE OTHER HEALTH INSURANCE COVERAGE MAY BE SUBJECT TO A TAX PENALTY. PLEASE CONSULT A TAX ADVISOR.

TABLE OF CONTENTS

SCHEDULE

Policyholder	BA, Holdings, Inc.
Eligible Class	Employees of BA, Holdings, Inc. who meet the eligibility requirements and who are Actively at Work, and their eligible Dependents.
Description of Class	All eligible Employees working a minimum of 30 hours per week

The following Base Covered Benefits and Daily Benefit Amounts are applicable to the Covered Person, only if elected at the time of enrollment

Covered Benefits- Option 1	**Daily Benefit Amount**
Hospital Admission Benefit	$500
Daily Hospital Confinement Benefit	$100
Daily Intensive Care Unit Confinement Benefit	$100
Intensive Care Unit Admission Benefit	$500
Covered Benefits- Option 2	**Daily Benefit Amount**
Hospital Admission Benefit	$1,000
Daily Hospital Confinement Benefit	$150
Daily Intensive Care Unit Confinement Benefit	$150
Intensive Care Unit Admission Benefit	$1,000
Covered Benefits- Option 3	**Daily Benefit Amount**
Hospital Admission Benefit	$1,500
Daily Hospital Confinement Benefit	$200
Daily Intensive Care Unit Confinement Benefit	$200
Intensive Care Unit Admission Benefit	$1,500

SCHEDULE (continued)

Portability	Included
• Portability Policy Age Limit	Coverage continued under Portability terminates at Age 75
Wellness Benefit Rider	$50

Maximum Age for Dependent Child: 26 years

Premium Rate Change: The premium may change on any Premium Due Date if rates for the person's Class are changed under the group Policy.

GENERAL DEFINITIONS

The male pronoun, whenever used in the Certificate, includes the female.

Accident: an unforeseen occurrence which results in bodily Injury to a Covered Person or Dependent while coverage is in force.

Active Work or Actively at Work: the Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week shown in the Description of Class in the Schedule.

Unless disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave).

Certificate: this document which provides a description of the insurance provided by the Policy issued to the Policyholder. It describes the essential features of the coverage and to whom benefits are payable.

Change in Family Status:

1. a change in marital status (marriage, divorce, legal separation, annulment);
2. a change in the number of dependents for tax purposes (birth, legal adoption of a child, placement of a child with the Covered Person for adoption, or death of a dependent);
3. certain changes in employment status that affect benefits eligibility for the Covered Person, spouse or child, such as termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (between full-time and part-time work, decrease or increase in hours);
4. a significant increase in the cost of coverage or a significant reduction in the benefit coverage under the Covered Person's insurance or his spouse's insurance; or
5. the addition, elimination, or significant curtailment of, a coverage option.

Complications of Pregnancy: a condition whose diagnosis is distinct from pregnancy, but adversely affected or caused by pregnancy, such as:

1. acute nephritis or nephrosis;
2. cardiac decompensation;
3. missed abortion;
4. similar medical and surgical conditions of comparable severity;
5. non-elective cesarean section;
6. termination of ectopic pregnancy; or
7. spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

However, the term Complications of Pregnancy will not include:

1. false labor, occasional spotting, hyperemesis gravidarum, pre-eclampsia or morning sickness; or
2. physician prescribed rest; or
3. any similar condition associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complications of Pregnancy.

Confined or Confinement: being an Inpatient in a Hospital due to a covered Injury or Sickness.

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: the Employee insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

Custodial Care: the provision of services and supplies for activities of daily living that can be provided safely and reasonably by individuals who are neither skilled nor licensed medical personnel.

Dependent: the Covered Person's Spouse or Child, as defined below.

Spouse: a legal spouse includes a Domestic Partner,as defined in the Policy. We may require proof of marriage, or proof of valid domestic partnership.

A Child is an unmarried Child under the Maximum Age for Dependent Child shown in the Schedule and who is:

1. a natural Child;
2. a stepchild;
3. a legally adopted Child;
4. a Child placed for adoption;
5. a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person's Spouse: or
6. a foster child, or any child who lives with the Covered Person in a regular parent-child relationship, provided the Covered Person claims such Child as a Dependent on the Covered Person's most recent federal income tax return.

The Child will cease to be an eligible Dependent on the last day of the month following the date the Child reaches the Maximum Age for Dependent Child unless the Child is an Incapacitated Child.

A Child is an Incapacitated Child if he is:

1. covered under the Policy on the date that he reaches the Maximum Age for Dependent Child;
2. unmarried;
3. physically or mentally disabled;
4. financially dependent upon the Covered Person; and
5. meets the conditions stated in the Continuation of an Incapacitated Child provision.

No one can be a Dependent of more than one Covered Person.

Domestic Partner: a person with whom the Employee has established a domestic partnership and filed a valid Declaration of Domestic Partnership with the California Secretary of State or an equivalent document for registration of a domestic partnership with an authorized state or municipal agency. We must be notified if the domestic partnership terminates.

Emergency Room: a special, designated area in a Hospital that is supervised by Physicians and equipped and staffed to render immediate medical attention on an Outpatient basis, 24 hours a day, seven days a week for the sudden onset of symptoms related to an Injury or Sickness. An Emergency Room is not a clinic, an Urgent Care Facility or Physician's office.

Employee: a person who is authorized to work for the Employer on a regular basis and is:

1. directly employed in the normal business of the Employer;
2. paid for services by the Employer; and
3. Actively at Work for the Employer, or any subsidiary or affiliate insured under the Policy.

No director or officer of an Employer will be considered an Employee unless he meets the above conditions.

Employer: the Policyholder and includes any division, subsidiary, or affiliated company named in the Policy. Employer does not include Employers of other related areas of practice for which the Covered Person may also work.

Enrollment:

Enrollment Period - the Initial Enrollment Period or Re-Enrollment Period.

Initial Enrollment Period - the period during which the Employee may first apply in writing for insurance.

Re-Enrollment Period: the period of time following the Initial Enrollment Period determined by the Employer and Us during which the Covered Person may apply in writing for insurance under the Policy or change his insurance under the Policy.

Hospital: an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and Treatment of sick and injured persons on an Inpatient basis;
3. operates facilities for medical and surgical diagnosis and Treatment by or under the supervision of a staff of legally qualified Physicians;
4. provides 24 hour a day nursing service by or under the supervision of registered graduate Nurses (R.N.s); and
5. is located within the United States or its territories and is approved by the Joint Commission on the Accreditation of Hospitals (JCAH).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home or Skilled Nursing Facility;
2. a Rehabilitation Center;
3. a place for rest, Custodial Care, or for the aged;
4. a clinic; or
5. unless otherwise specified within this Certificate, a place for the Treatment of Mental and Nervous Disorders, alcoholism or drug addiction.

Immediate Family: a person's spouse or domestic partner, child, parent or sibling; or the spouse's or domestic partner's child, parent or sibling.

Injury: bodily harm.

Inpatient: admission to a Hospital for at least 20 hours
for which a full day's room and board charge is made.

It does not include an Emergency Room admission, any Outpatient Treatment or any stay in an Observation Unit when there is no charge for room and board.

Intensive Care Unit: a Hospital area of special care, including cardiac and coronary care units, surgical intensive care units or cardiovascular intensive care units, which at the time of admission are separate and apart from the surgical recovery room, or other rooms, beds or wards normally used for patient Confinement.

In addition, such a unit must provide the following:

1. 24 hour continuous nursing care and attendance by Nurses assigned to the unit on a full-time basis;
2. direction and/or supervision by a full-time Physician director or a standing intensive care committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

The following do not qualify as Hospital Intensive Care Units:

1. progressive care units;
2. sub-acute intensive care units;
3. intermediate care units;
4. private rooms with monitoring;
5. step-down units; or
6. any other lesser care treatment units.

Mental and Nervous Disorder: any Sickness, disease or disorder, which is:

1. listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (or any successor diagnostic manual) published by the American Psychiatric Association; and
2. generally treated by a licensed mental health provider or other qualified provider, using psychotherapy, psychotropic drugs or other similar methods of Treatment.

Mental and Nervous Disorder includes any such conditions whether or not related to an underlying physical, genetic, chemical, organic or biological cause, although it may be associated with physical symptoms, manifestations or expressions. Specific conditions include, but are not limited to: bipolar disorder; depression and depressive disorders; psychoses; mood disorders; manic-depressive illness; anxiety disorders; stress disorders including post-traumatic stress disorders; somatoform disorders; factitious disorders; eating disorders; adjustment disorders; and personality disorders. However, for purposes of the Policy, Mental and Nervous Disorder does not include coma (unless a consequence of Substance Abuse), mental retardation or Alzheimer's disease and other forms of dementia with an objectifiable organic basis.

Nurse: any one of the following who is not a member of the Covered Person's Immediate Family:

1. licensed practical Nurse (L.P.N.);
2. licensed vocational Nurse (L.V.N.); or
3. registered graduate Nurse (R.N.).

Observation Unit: a specialized area within a Hospital, apart from the Emergency Room, where a patient can be monitored following Outpatient Surgery or Treatment in the Emergency Room by a Physician. Such a unit must:

1. be under the direct supervision of a Physician or registered graduate Nurse (R.N.);
2. be staffed by Nurses assigned specifically to that unit; and
3. provide care seven days per week, 24 hours per day.

Outpatient: Treatment for which a Confinement is not required and no charge is made for room and board.

Period of Confinement: an interval of time during which a Covered Person or Dependent is Confined as an Inpatient. A Period of Confinement begins on the date of admission. Successive Confinements commencing while coverage is in force, and:

1. due to the same or related causes; and
2. separated by less than 90 days;

are part of the same Period of Confinement.

A new Period of Confinement begins when the Covered Person is admitted:

1. for a new Injury or Sickness unrelated to the causes of a prior Confinement; or
2. after he has not been Confined for 90 days or more.

Physician: a person:

1. performing tasks that are within the limits of his medical license; and
2. who is licensed to practice medicine and prescribe and administer drugs or to perform Surgery; or
3. who is a legally qualified medical practitioner according to the laws and regulations of the state he practices in.

For the purposes of the Policy, the term Physician does not include the Covered Person, the Covered Person's spouse, domestic partner, or any Immediate Family members.

Policy: the legal contract between the Policyholder and Us and it may be changed or discontinued without the consent of the Covered Person or the Covered Person's beneficiary. The Policy may be inspected at the office of the Policyholder.

Policy Anniversary Date: the annual renewal date of the group insurance contract between Us and the Policyholder.

Policyholder: the group named as the Policyholder on the first page of this Certificate.

Rehabilitation Center: a facility providing therapy and training for rehabilitation. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. A Rehabilitation Center is not:

1. a nursing home;
2. an extended care facility;
3. a Skilled Nursing Facility;
4. a rest home or home for the aged;
5. a hospice care facility;
6. a place for the care of drug addicts or alcoholics; or
7. an assisted living facility.

Sickness: an illness, disease, pregnancy or Complications of Pregnancy.

Skilled Nursing Facility: an institution which:

1. operates pursuant to law;
2. primarily and continuously provides skilled nursing care and related services to persons recuperating from Injury or Sickness on an Inpatient basis for which a charge is made;
3. maintains a daily medical record of each patient;
4. has established policies developed and executed by a professional group including at least one legally qualified Physician and at least one registered graduate Nurse (R.N.);
5. provides adequate procedures for the administration of drugs;
6. provides each patient with a planned program of medical care by or under the supervision of a Physician; and
7. has a qualified Physician available to furnish medical care in case of emergency.

Skilled Nursing Facility or convalescent Hospital does not mean any institution or part thereof used principally as:

1. a Hospital;
2. a rest home, a home for the aged, or a place for Custodial Care; or
3. a place for the care of drug addicts, alcoholics, or the mentally ill.

If an institution has multiple licenses or purposes, a separate portion, ward, wing or unit thereof can qualify as a Skilled Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing skilled nursing care and related services in accordance with the authority granted by its license.

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

Surgery: manual procedures involving cutting of body tissue, debridement or permanent joining of body tissue for repair of wounds, Treatment of fractured bones or dislocated joints, endoscopic procedures, and other manual procedures, when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Treatment: Any consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

Urgent Care Facility: a category of walk-in clinic focused on the delivery of Treatment in a dedicated medical facility outside of a traditional Emergency Room. Urgent Care Facilities primarily treat Injuries or Sicknesses requiring immediate care.

We, Our and Us: UnitedHealthcare Insurance Company or its Administrator.

HOSPITAL ADMISSION BENEFIT

Hospital Admission Benefit: We will pay the Daily Benefit Amount shown for this benefit in the Schedule for the first day a Covered Person or Dependent is admitted and Confined in a Hospital as an Inpatient as a result of an Injury or Sickness.

This benefit is payable up to 1 day per plan year per Covered Person or Dependent. This benefit is payable once per Period of Confinement in a Hospital per Covered Person or Dependent.
We will pay the Daily Benefit Amount for the Hospital Admission Benefit in addition to the Daily Benefit Amount for the Intensive Care Unit Admission Benefit.

The Hospital Admission Benefit is not payable for:

1. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
2. admissions to Skilled Nursing Facilities and Rehabilitation Centers;
3. Treatment for Mental and Nervous Disorders;
4. Treatment for drug and alcohol addictions;
5. Emergency Room Treatment, Outpatient Surgery or Treatment, or a Hospital stay of less than 20 hours in an Observation Unit; or
6. when a charge for a Hospital room and board is not made.

UHIHIP-FDHC

DAILY HOSPITAL CONFINEMENT BENEFIT

Daily Hospital Confinement Benefit: We will pay the Daily Benefit Amount shown for this benefit in the Schedule for each day that a Covered Person or Dependent is Confined in a Hospital as a result of an Injury or Sickness.

This benefit is payable for each day during a Period of Confinement in a Hospital up to a maximum of 365 days per plan year per Covered Person or Dependent.

If the Hospital Admission Benefit is also payable, this benefit pays for each day after the first day during a Period of Confinement in a Hospital up to a maximum of 364 days.
The Daily Hospital Confinement Benefit is not payable for:

1. any day for which the Hospital Admission Benefit is payable;
2. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
3. admissions to Skilled Nursing Facilities and Rehabilitation Centers;
4. Treatment for Mental and Nervous Disorders;
5. Treatment for drug and alcohol addictions; or
6. when a charge for a Hospital room and board is not made.

UHIHIP-DHC

DAILY INTENSIVE CARE UNIT CONFINEMENT BENEFIT

Daily Intensive Care Unit Confinement Benefit: We will pay the Daily Benefit Amount shown for this benefit in the Schedule for each day that a Covered Person or Dependent is Confined in an Intensive Care Unit of a Hospital as an Inpatient, as a result of an Injury or Sickness.

We will pay the Daily Benefit Amount for each day during a Period of Confinement in the Intensive Care Unit up to a maximum of 365 days per plan year per Covered Person or Dependent.
If the Hospital Admission Benefit is also payable, this benefit pays for each day after the first day during a Period of Confinement in a Hospital up to a maximum of 364 days.
The Daily Intensive Care Unit Confinement Benefit is not payable for:

1. any day for which the Intensive Care Unit Admission Benefit is payable;
2. Treatment for Mental and Nervous Disorders;
3. Treatment for drug and alcohol addictions; or
4. when a charge for Intensive Care Unit room and board is not made.

UHIHIP-DICU

INTENSIVE CARE UNIT ADMISSION BENEFIT

Intensive Care Unit Admission Benefit: We will pay the Daily Benefit Amount shown for this benefit in the Schedule, for the first day a Covered Person or Dependent is admitted and Confined in an Intensive Care Unit of a Hospital as an Inpatient, as a result of an Injury or Sickness.

This benefit is payable up to 1 day per plan year per Covered Person or Dependent. This benefit is payable once per Period of Confinement in an Intensive Care Unit per Covered Person or Dependent.
We will pay the Daily Benefit Amount for the Intensive Care Unit Admission Benefit in addition to the Daily Benefit Amount for the Hospital Admission Benefit.

The Intensive Care Unit Admission Benefit is not payable for:

1. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
2. Treatment for Mental and Nervous Disorders;
3. Treatment for drug and alcohol addictions;
4. Emergency Room Treatment, Hospital admission, Outpatient Surgery or Treatment; or
5. when a charge for Intensive Care Unit room and board is not made.

UHIHIP-FDICU

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who are Actively at Work are eligible for insurance provided :

1. they are in a class of Employees who are included; and
2. customarily working at least the number of hours per week shown in the Schedule.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the date the Policy is changed to include the Employee's class; or
3. the date the Employee enters a class eligible for insurance.

Dependent Eligibility: Dependents are eligible for insurance on the latest of the following dates:

1. the date the Covered Person becomes eligible for Dependent Insurance;
2. the date a person becomes a Dependent; or
3. the date the Policy is amended to include the Covered Person's class as being eligible for Dependent Insurance.

The Dependent will not be eligible for Dependent Insurance if he:

1. is eligible for insurance under the Policy as a Covered Person; or
2. is a member of the armed forces on active duty, except for duty of 30 days or less for training in the Reserves or National Guard.

Enrolling in or Changing Insurance for Covered Person Insurance Under the Policy: The Employee may enroll in or change his insurance only under the following situations:

1. during the Initial Enrollment Period:
    a. if the Employee is eligible for insurance on the Effective Date, he may enroll for insurance during the Initial Enrollment Period. If an Employee fails to enroll, then he will not be insured under the Policy; or
    b. if the Employee becomes eligible for insurance after the Effective Date, he may enroll for insurance during his Initial Enrollment Period.
2. during a Re-enrollment Period: The Employee may choose:
    a. to keep his same insurance;
    b. no insurance under the Policy;
    c. to enroll for insurance if not currently insured under the Policy; or
    d. to change any benefit or amount that is optional.
3. within 31 days of a Change in Family Status, as defined, the Employee may choose to enroll or change the insurance for which he is eligible.

During a Re-enrollment Period, if the Covered Person does not re-enroll for insurance, he will continue to be insured for the same insurance.

Enrolling in or Changing Dependent Insurance Under the Policy:
The Employee may elect or change Dependent insurance only under the following situations:

1. during the Initial Enrollment Period:
    a. if the Dependents are eligible for insurance on the Effective Date of the Policy, the Employee may enroll for Dependent insurance during the Initial Enrollment Period. If an Employee fails to enroll his Dependents, then the Dependents will not be insured under the Policy; or
    b. if the Dependents become eligible for insurance after the Effective Date of the Policy, the Employee may enroll for Dependent insurance during his Initial Enrollment Period.
2. during a Re-enrollment Period: The Employee may choose:
    a. to keep the same Dependent insurance;
    b. no Dependent insurance under the Policy;
    c. to apply for Dependent insurance under the Policy; or
    d. to change any benefit or amount of Dependent insurance that is optional.
3. within 31 days of a Change in Family Status, as defined, the Employee may choose to enroll or change his Dependent insurance provided the Dependent is eligible.

The Employee may enroll for:

1. Dependent insurance for Spouse only;
2. Dependent insurance for Children only; or
3. Dependent insurance for both Spouse and Children.

During a Re-enrollment Period, if the Covered Person does not re-enroll for Dependent insurance, his Dependents will continue to be insured for the same insurance until the next Re-enrollment Period.

Dependents will not be insured until the Employee is insured. Dependents are not eligible for any benefit or amount that is more than the Covered Person's.

Effective Date of Covered Person Initial Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory and the Employee applies within:
    a. 31 days of the date he first became eligible for insurance, on the later of:
        i. the date the Employee became eligible for insurance; or
        ii. the date we approve the Employee's application if evidence of insurability is required;
    b. 31 days of a Change in Family Status, on the latest of:
        i. the date of the Change in Family Status;
        ii. the date the Employee became eligible for the insurance; or
        iii. the date we approve the Employee's application if evidence of insurability is required.

Effective Date of Dependent Initial Insurance: No insurance will take effect on any day the Dependent is Confined in a Hospital or medical facility. Insurance will take effect on the day following discharge from the Hospital or medical facility.

A Covered Person must use forms provided by Us when applying for Dependent insurance.

The Dependent insurance will be effective at 12:01 A.M. Eastern Standard time :

1. if it is Non-contributory, on the date the Dependent becomes eligible for insurance regardless of when application was made; or
2. if it is Contributory and the Employee applies for coverage of his Dependent within:
    a. 31 days of the date the Dependent first became eligible for insurance, on the later of:
        i. the date the Dependent became eligible for insurance; or
        ii. the date we approve the application if evidence of insurability is required;
    b. 31 days of a Change in Family Status, on the latest of:
        i. the date of the Change in Family Status;
        ii. the date the Dependent became eligible for the insurance; or
        iii. the date we approve the application if evidence of insurability is required.
3. Evidence of Insurability is not required for Dependent Children.

Dependents will not be insured until the Employee is insured.

Effective Date of Change in Covered Person or Dependent Insurance: A change in insurance that is made during a Re-enrollment Period will be effective at 12:01 a.m. Eastern Standard time on the later of:

1. the date of application;
2. the first day of the pay period for which contributions for his insurance are deducted; or
3. the date the Covered Person or Dependent becomes eligible for the change in insurance, regardless of when application is made.

If the Covered Person is not Actively at Work due to Injury or Sickness, or is on a layoff or leave of absence, any increase in or addition to the Covered Person or Dependent insurance will be effective on the date the Covered Person returns to Active Work.

Newborn Child Provision: The Covered Person's Newborn Child will become covered by the Policy from the moment of live birth. The Newborn Child will be covered for the Benefit Amount that applies to the Covered Person's other Children covered under the Policy. If the Covered Person has no other Children covered, then the lowest amount available to Children under the Policy applies. The Child's coverage will cease on the 31st day next following the Child's effective date unless:

1. We receive written request and any required premium to continue coverage for the Child before that date; or
2. the Covered Person's other children are covered, and We received written request and any required premium for the Child within 31 days of the day We first deny a claim on the basis that the child is not enrolled.

Termination of Covered Person's Insurance: The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date he becomes a member of the armed forces on active duty, except:
    a. for duty of 30 days or less for training in the Reserves or National Guard; or
    b. to the extent coverage is continued under the Leave of Absence Continuation provision;
3. the date he ceases to be a member of a class eligible for insurance;
4. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates; or
5. the date he ceases to be Actively at Work, unless Active Work ceases during an approved layoff, medical or non-medical leave of absence, then the insurance will continue for up to 3 months from the date he stopped Active Work; or
6. the date he is no longer Actively at Work due to a labor dispute, including but not limited to strike, work slow down or lock out.

Termination of Dependent insurance: Insurance on a Dependent will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the date he ceases to be a Dependent as defined in the Policy;
2. the date he ceases to be a member of a class eligible for Dependent insurance;
3. the date the Covered Person's insurance under the Policy terminates;
4. the date the Dependent becomes a member of the armed forces on active duty, except:
    a. for duty of 30 days or less for training in the Reserves or National Guard; or
    b. to the extent coverage is continued under the Continuation During Leave of Absence provision;
5. the last day of the period for which a Dependent's required premium payment is made, if the next payment is not made; or
6. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates.

CONTINUATION AND REINSTATEMENT PROVISIONS

Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by Us or Our agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon Our approval of such application or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss sustained after the date of reinstatement. In all other respects the insured and We shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Continuation during Leave of Absence: If the Covered Person is on Family or Medical Leave of Absence, or other leave of absence required by an applicable state or federal law, continuation of his insurance will be governed by his Employer's Policy on such leave not to exceed the greater of:

1. the leave period required by the Family and Medical Leave Act of 1993 (FMLA)
2. the leave period required by the Uniformed Services Employment and Reemployment Rights Act (USERRA); or
3. the minimum leave period required by applicable state law.

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid.

If the Covered Person's insurance does not continue during such Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Continuation of an Incapacitated Child: If, on the date a Child reaches the Maximum Age for Dependent Child as shown in the Schedule, he is:

1. covered under the Policy; and
2. an Incapacitated Child, as defined;

his coverage will not terminate solely due to age. The Covered Person must give Us notice of the incapacity within 31 days of the termination date.

The Child's coverage will continue as long as:

1. the Child qualifies as an Incapacitated Child; and
2. the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We cannot require proof more than once each year.

Reinstatement of Rehired Employees: If a Covered Person ends employment and is rehired within 30 days, he may be insured on his eligibility date for the insurance that he had under the Policy on the date his employment ended.

Reinstatement following Military Service: If the Covered Person's or Dependent's insurance under the Certificate terminates due to active duty in one of the uniformed services of the United States military, he will have the right to renew coverage on the same basis as before the suspension in the coverage took place, provided:

1. he is in the service for a period of five years or less;
2. he applies for reinstatement of coverage and pays the required premium within 60 days of his discharge from the service; and
3. the Policy is still in force, he is eligible for coverage, and he is Actively at Work.

As used above, uniformed services includes service in the uniformed services as defined in Chapter 43 of Title 38. Coverage will be reinstated without evidence of insurability. The coverage will become effective on the first day of the month after military service terminates. However, the Policy will not cover loss or other disability resulting from the military service.

PORTABILITY

Portability: If the Covered Person's and his Dependent's insurance under the Policy ends because his employment with the Employer ends, he may choose to continue his and his Dependent's Group Hospital Indemnity's coverage under the Policy without providing evidence of insurability.

The Covered Person must be insured under the Policy prior to the date his employment ends.

The Covered Person may port his insurance or his Dependent's insurance if coverage ends for any reason other than :

1. he failed to pay premium for the cost of his insurance;
2. he is on an approved leave of absence;
3. the group Policy is terminating;
4. he is or becomes insured under another Hospital Indemnity policy;
5. he resides outside of the United States or in a state where the coverage is not available; or
6. he is actively in military service or entering active military service.

To apply for Portability insurance, within 31 days of the date the Covered Person's insurance ends he must:

1. submit a written application to Us; and
2. pay the first month's premium.

If the above conditions are met, such insurance will:

1. be issued without evidence of insurability; and
2. continue in effect provided the Covered Person continues to pay the cost of his and his Dependent's insurance.

The Portability insurance will end on the earliest of:

1. the date the Covered Person fails to pay the required premium;
2. the date he becomes insured under any other Hospital Indemnity policy; or
3. the date he attains any Policy Age Limit shown in the Policy.

Covered Persons rehired after porting insurance must either lapse his and his Dependent's insurance or provide evidence of insurability.

The Portability coverage will be on the form the Insurer is then issuing for Hospital Indemnity Portability purposes.

Insurer as used in this provision means Us or another insurance company which has agreed with Us to issue Portability coverage according to this Portability provision. The Portability coverage may differ from Your coverage under the Policy. The premium for the Portability coverage will be based on the coverage and form of the Policy, as well as Your age and risk class.

Portability Premium Contribution: For the first 12 months of Portability, the Covered Person's rate will be the group's current rate for the Covered Person's class. However, the Covered Person must pay the full premium including any part previously paid by his Employer.

After the first 12 months, the rate changes to a Portability rate which may be higher.

Eligibility Age Limit: The Covered Person must be under Age 70 to apply for Portability. To include Dependent coverage, the Covered Dependent must also be under Age 70.

Portability Termination Age: A Covered Person's and Dependent's Portability coverage will terminate on the first day of the month following the date he attains Age 75. If the Covered Person's Portability coverage terminates, his Dependent's coverage also terminates.

GENERAL EXCLUSIONS AND LIMITATIONS

General Exclusions and Limitations: This Certificate does not cover any loss caused by or resulting from (directly or indirectly):

1. an act or Accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any loss which is intentionally self-inflicted;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician, this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
7. Treatment received outside the United States or its territories;
8. the reversal of a tubal ligation or vasectomy;
9. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician services, unless required by law;
10. participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
11. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
12. driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway;
13. Mental and Nervous Disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;
14. dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an Injury; or (b) correct a disorder of normal bodily function; and
15. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

Cosmetic or Elective Surgery Exclusion: We will not cover any loss under the Policy if it is due to Cosmetic Surgery or Elective Surgery.

Cosmetic Surgery means surgery performed to modify or improve the appearance of a physical feature or defect. For purposes of excluding benefits, Cosmetic Surgery does not mean Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by:

1. congenital defects;
2. developmental abnormalities;
3. trauma;
4. infection;
5. tumors; or
6. disease;

when intended to either improve function or create a normal appearance to the extent possible.

Reconstructive Surgery includes:

1. dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; and
2. surgery and prosthetic devices to restore and achieve symmetry incident to a mastectomy.

Elective Surgery means:

1. Cosmetic Surgery; and
2. any other surgery that is:
   a. not for the purpose of correcting or repairing abnormal structures of the body;
   b. not for the purpose of improving function; or
   c. if intended to improve appearance or create a normal appearance, is not caused by a condition listed in 1-6 above.

For purposes of excluding benefits, Elective Surgery does not include:

1. Caesarean section;
2. any surgery related to Complications of Pregnancy; or
3. bariatric surgery performed in conjunction with a diagnosis of morbid obesity.

GENERAL PROVISIONS

Time Limit on Certain Defenses:

1. After two years from the date of issue of the policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.
2. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under the policy.

Grace Period: A grace period of 60 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to Our right to cancel in accordance with the cancellation provision hereof).

Unpaid Premium: Upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Notice of Claim: Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Us at the administrative address shown on the face page of this certificate, or to any authorized agent of Ours, with information sufficient to identify the insured, shall be deemed notice to Us.

Claim Forms: Upon receipt of a notice of claim, We will provide to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to Us within 90 days after the date of loss or after the insurer becomes liable for periodic payments. Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Proof of Loss must include a completed claim form signed by the Covered Person and Physician(s) including documentation furnished by the Physician and supported hospital billing records.

Time of Payment of Claim: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Physical Examinations and Autopsy: We, at Our own expense shall have the right and opportunity to examine the person of the insured when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been provided. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be provided

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Misstatement of age: If the age of the insured has been misstated, all amounts payable under the policy shall be such as the premium paid would have purchased at the correct age.

Cancellation: We may cancel the policy at any time by written notice delivered to the Policyholder, or mailed to his last address as shown by Our records, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the Policyholder may cancel the policy at any time by written notice delivered or mailed to Us, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation by either the Policyholder or Us, We will return promptly the unearned portion of any premium paid. The Policyholder shall pay, on a pro rata basis, the earned premium which has not been paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Upon providing the Policyholder with notice of Our intent to cancel, We will cease accepting applications under the Policy. However, the Policy will not terminate with respect to inforce certificates until the last certificate cancels in accordance with its termination provisions and no person remains insured under the Policy. The Policy will only terminate earlier with respect to inforce certificates if We and the Policyholder:

1. agree to such termination;
2. arrange separately or jointly for coverage under any inforce certificate to transition to a new policy; and
3. the new policy continues such coverage for the same or similar benefits.

The Termination of an Insurance Option under the Policy: We may cancel or modify any Insurance Option if the number of Employees insured falls below the greater of:

1. 10 Covered Persons; or
2. 10% of all eligible Employees.

Conformity With State Statutes: Any provision of the policy which, on its effective date, is in conflict with the statutes of California, is hereby amended to conform to the minimum requirements of such statutes.

Fraud: The falsity of any statement in the application for coverage shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Us.

Workers' Compensation: The Policy is not to be construed to provide benefits required by Worker's Compensation laws.

WELLNESS BENEFIT RIDER

It is agreed that the Policy and Certificate are amended by the addition of the following Wellness Benefit:

We will pay the amount shown on the Schedule per calendar year for any one of the following health screening tests performed on either the Covered Person or Spouse provided the Covered Person elected coverage under the benefit.

Health screening test is defined as:

- Generally medically accepted cancer screening tests including, but not limited to:
  - Mammography
  - CA 15-3 (blood test for breast cancer)
  - CA 125 (blood test for ovarian cancer)
  - CEA (blood test for colon cancer)
  - an annual cervical cancer screening test which includes a conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, or the option of any cervical cancer screening test approved by the federal Food and Drug Administration
  - PSA (blood test for prostate cancer)
  - Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Thermography
- Virtual Colonoscopy

This benefit will be paid as long as the Policy is in force and the Covered Person or Spouse remains insured under this Rider of the Policy. The benefit will be paid regardless of the results of the test. The Wellness Benefit is paid in addition to any other payments the Covered Person or Spouse receives under the Policy.

Only one health screening test will be covered upon receipt by Us of adequate documentation to support the performance of the test on the Covered Person or Spouse.

Interaction with Wellness Benefit: If the Covered Person has purchased this Wellness Benefit under more than one policy issued by UnitedHealthcare Insurance Company, the Wellness Benefit for any health screening test is payable only once per calendar year, regardless of any other such benefit. Another Wellness Benefit is only payable if it is for a different health screening test issued under a separate policy.

Signed for the Company by:

Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

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

• hospitalization

• physician services

• hospice

• outpatient prescription drugs if you are enrolled in Medicare Part D

• other approved items and services

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program SHIP.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

Important notice about your Hospital Indemnity Plan.

What is a Hospital Indemnity Plan?

A hospital indemnity plan is not health insurance that pays medical expenses. This is a plan that pays a set amount of money when you are in the hospital.

What do I need to know?

The Affordable Care Act (health care reform) requires insurance companies to provide minimum coverage for certain medical benefits. This is called essential health benefits.

Why is this important to me?

You need to know that your hospital indemnity plan is not a substitute for health insurance that pays medical expenses. This plan doesn't provide essential health benefits. This is why you also need health insurance for medical expenses.

What happens if I don't have health insurance for medical expenses?

The Affordable Care Act requires everyone to have health insurance for medical expenses. This hospital indemnity plan is not enough to meet the requirement. You must also have health insurance for medical expenses.

California Consumer Complaint Notice

If the Covered Person has any questions or problems with their coverage, We will be ready to help. Our contact information is:

UnitedHealthcare Insurance Company

A Stock Company

Administrative Offices: 9900 Bren Road East, Minnetonka, MN 55343

1-888-299-2070

The Covered Person may also call the California Department of Insurance for assistance. However, We ask that the Covered Person gives Us the opportunity to try to resolve the problem. Please, call us first. If, We fail to help, the Covered Person may still ask the California Department of Insurance for assistance. Their contact information is:

California Department of Insurance

Consumer Services Division

300 South Spring Street

Los Angeles, California 90013

1-800-927-HELP

(1-800-927-4357)

http://www.insurance.ca.gov/01-con

CERTIFICATE MODIFICATIONS RIDER

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance

80% of death benefits but not to exceed $300,000
80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

CERTIFICATE MODIFICATIONS RIDER

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

CERTIFICATE MODIFICATIONS RIDER

Modification(s) to the Certificate

Policyholder: BA Holdings, Inc.

Policy Number: 371448

It is agreed that the Certificate is amended as follows:

Effective January 1, 2024, with respect to residents of the states as shown on the subsequent pages, the following provisions amend, replace or are added, when applicable, to the Certificate, and all other conditions apply.

Signed for UnitedHealthcare Insurance Company by:

Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut 06103-3408

CERTIFICATE MODIFICATIONS RIDER

STATUTORY PROVISIONS

ALASKA

Residents of the state of Alaska the following provisions are included to bring your Certificate into conformity with Alaska state law:

General Definitions
If Dependent coverage is included and **Domestic Partner and Civil Union** are defined, they are amended so that any references to gender (i.e., "of the opposite or same sex" or "of the same sex") are removed.

General Exclusions and Limitations
The Treatment received outside of the United States exclusion is amended to add "or Canada."

Claim Provisions
Overpayment of Claim is amended to advise that we have the right to recover any overpayments within 180 days of payment of a benefit.

ARKANSAS

Residents of the state of Arkansas, the following provisions are included to bring your Certificate into conformity with Arkansas state law:

Insurer Information Notice

Any questions regarding the Policy may be directed to:

UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
1-866-615-8727

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 77202

Continuation and Reinstatement Provisions
If Dependent coverage is included, **Continuation of an Incapacitated Child** is amended to remove the 31 day notice requirement of the incapacity.

FLORIDA

Residents of the state of Florida:

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida

The following provisions are included to bring your Certificate into conformity with Florida state law:

Dependent Definition

If Dependent coverage is included, the definition of **Child** is amended to include foster Child(ren).If Dependent coverage is included and **Domestic Partnership** is defined, it is amended to remove any specific living arrangements and affiliated time period requirements.

If Dependent coverage is included, the definition of **Incapacitated Child** is amended to remove any requirement that the Child be unmarried.

If **Mental and Nervous Disorder** coverage is included, it is amended to remove "mental retardation or Alzheimer's disease and other forms of dementia with an objectifiable organic basis."

Eligibility, Effective Date and Termination Provisions

If Dependent coverage is included, **Newborn Child Provision** is amended to include an adopted Child. The adopted Child will become insured on the date the Child was placed with You for adoption at the same Benefit Amount that applies to Your other Children. If no other Children are insured, then the lowest amount available to Children under the Policy applies until We are notified of another amount that is available for Children. The timeframe for notification of, and premium payment for, a newborn or adopted Child is extended to 60 days; and insurance for the newborn/adopted Child may end on the date You request.

Claim Provisions

Legal Actions is amended to extend the timeframe in which no suit may be brought from three years after the date of loss to five years.

IDAHO

Residents of the state of Idaho, the following provisions are included to bring your Certificate into conformity with Idaho state law:

10 Day Free Look: The Covered Person has the right to return this certificate within 10 days of its delivery and to have any premium paid, refunded if after examination, he is not satisfied for any reason.

Notice to Buyer: This is a Hospital Indemnity Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate carefully with the outline of coverage.

Insurer Information Notice

Any questions regarding the Policy may be directed to:

UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
1-866-615-8727

If the question is not resolved, you may contact the Idaho Department of Insurance:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

The following Outline of Coverage is included:

GROUP HOSPITAL CONFINEMENT INDEMNITY COVERAGE

THIS CERTIFICATE PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE for UHIHIP-POL-ID-1

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

10 Day Free Look: You have the right to return this certificate within 10 days of its delivery and to have any premium paid, refunded if after examination, you are not satisfied for any reason.

(1) Read Your Certificate Carefully—This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR CERTIFICATE CAREFULLY!**

(2) Hospital confinement indemnity coverage is designed to provide coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered injury or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

(3) Amount and Duration of Benefits: The coverage pays you or your Dependent (if applicable) the Maximum Benefit Amount for each Benefit shown on the Certificate Schedule, subject to all the terms, limits, and exclusions of the policy.

Refer to the Certificate Schedule for:

a. Maximum Benefit Amount; and
b. Any Additional Benefits that apply

(4) Exceptions, Reductions and Limitations: We will not cover any loss caused by or resulting from (directly or indirectly):

1. an act or Accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any loss which is intentionally self-inflicted;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician, this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
7. Treatment received outside the United States or its territories;
8. the reversal of a tubal ligation or vasectomy;
9. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician services, unless required by law;
10. participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
11. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
12. driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway;
13. Mental and Nervous Disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;
14. dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an Injury; or (b) correct a disorder of normal bodily function; and
15. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

Renewability: You will cease to be a Covered Person and your insurance will terminate on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date he becomes a member of the armed forces on active duty;
3. the date he ceases to be a member of a class eligible for insurance;
4. the date the policy terminates, or with respect to a specific benefit, the date that such benefit terminates;
5. the date he ceases to be actively at work, unless active work ceases during an approved layoff, medical or non-medical leave of absence, then the insurance will continue for up to 3 months from the date he stopped active work; or
6. the date he is no longer actively at work due to a labor dispute, including but not limited to strike, work slow down or lock out.

UHIHIP-OOC-ID-1

General Definitions

If Dependent coverage is included, the definition of **Child** is amended to include: a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person's, Domestic Partner, partner in a Civil Union.

The **Complications of Pregnancy** definition is amended to remove "non-elective" from the cesarean section condition.

The **Hospital** definition is amended to include an institution which operates either on its premises or in facilities available to the hospital on a prearranged basis.

Benefits

Drug and Alcohol Treatment Benefit (Inpatient) / Mental and Nervous Disorder Treatment Benefit (Inpatient) / Rehabilitation Therapy Benefit (Inpatient) / Skilled Nursing Facility Benefit are amended to be payable up to 31 days.

Eligibility, Effective Date and Termination Provisions

If Dependent coverage is included, **Enrolling in or Changing Dependent Insurance Under the Policy** is amended to allow for 60 days of a Change in Family Status for a newborn or newly adopted child.

If Dependent coverage is included, the **Newborn Child Provision** is amended to include adopted newborn Children that are Placed with You within 60 days of the adopted Child's date of birth, and will become covered by the Policy from the moment of live birth. An adopted newborn Child Placed with You more than 60 days after their birth is covered by the Policy from and after the date the Child is so Placed. Placed means physical placement in the care of the adopting Covered Person. If physical placement is prevented due to the medical needs of the child, "placed" means the date the adopting Covered Person signs an agreement for adoption of the child and assumes financial responsibility for the child.

We must receive notification the Child within 60 days next following the date of birth, adoption or placement for adoption. The appropriate premium, if any, must be received within 31 days of the date the monthly premium invoice is received by the Policyholder and a notice of premium, if any, is provided to You by the Policyholder.

Coverage will cease unless We receive written request and any required premium as stated above.

The coverage amount offered is the lowest amount available to Children under the Policy if no other Children are insured, until We are notified of another amount that is available for Children.

A Congenital Anomaly refers to a condition existing at or from birth that is a Significant Deviation from the common form or function of the body. Congenital Anomaly is often caused by a hereditary or developmental defect or disease.

Significant Deviation means a deviation which impairs the function of the body and includes, but is not limited to, the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

General Limitations and Exclusions

The following exclusions are not applicable (if included in your Certificate):

- taking part in the commission of an assault or being engaged in an illegal activity;
- the reversal of a tubal ligation or vasectomy;
- artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician services, unless required by law;

The act of war exclusion is replaced with "an act of war, declared or undeclared, whether civil or international."

The felony exclusion is replaced with "active participation in a felony."

The use of alcohol exclusion is replaced with "Alcohol or drug addiction; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy."

The Cosmetic or elective surgery exclusion is amended to include “except that “cosmetic surgery” shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child.”

The participation in any form of aeronautics exclusion is replaced with “operating any aircraft as a professional for wage or profit.”

The driving in any organized or scheduled race or speed test exclusion is amended to include the requirement of driving or testing as a professional.

The Dental or plastic surgery exclusion is amended to include “or (c) reconstructive surgery because of congenital disease or anomaly of a Dependent Child.”

The practicing for or participating in any semi-professional or professional competitive athletic contests exclusion is amended to remove “semi-professional”.

Claim Information
Time of Claim Payment is added:

Time of Claim Payment: Benefits for loss covered by the Policy are paid upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.

MINNESOTA

Residents of the state of Minnesota, the following provisions are included to bring your Certificate into conformity with Minnesota state law:

General Definitions
If Dependent coverage is included, the definition of **Child** is amended to include a grandchild of either the Covered Person or the Covered Person’s Spouse who is financially dependent upon and who resides with the Covered Person or the Covered Person’s Spouse.

General Limitations and Exclusions
The use of alcohol exclusion is replaced with “use of narcotics, unless administered on the advice of a Physician.”

NORTH CAROLINA

Residents of the state of North Carolina, the following provisions are included to bring your Certificate into conformity with North Carolina state law:

Important Cancellation Information — Please Read the Provision Entitled, **Termination of Employee Insurance.**

General Definitions
The "change in the number of dependents" item in the **Change in Status** definition is amended to remove the requirement that it be for tax purposes. This item is also amended to include placement of a Child in a foster home.

If Dependent coverage is included, the definition of **Child** is amended to include the following: a non-custodial Child; a foster Child from the date they are placed in a foster home; or a Child for whom You are required to provide insurance due to a court or administrative order. An adopted Child's insurance is effective from the date of placement for the purpose of adoption and continues unless placement is disrupted prior to legal adoption and the child is removed from placement.

The definition of **Hospital** is amended to include: In North Carolina, Hospital also means a duly licensed State tax-supported institution which may be a specialty facility for one particular type of illness or one that may not have an operating room and related equipment for surgery. State tax-supported institutions includes community mental health centers and other health clinics which are certified as Medicaid providers.

Physician's Visit Benefit
If **Physician's Visit Benefit** is included, Chiropractic office visits are covered.

Surgery Benefit (Inpatient)/Surgery Benefit (Outpatient)
If **Surgery Benefit** (Inpatient) and/or **Surgery Benefit** (Outpatient) are included, the anesthesia benefit amount is changed from 25% of the Daily Benefit Amount to $12.50 per $50 of the Daily Benefit Amount Shown on the Schedule.

Eligibility, Effective Date and Termination Provisions
If Dependent coverage is included, the **Newborn Child Provision** includes Adopted and Foster Children.

Continuation of an Incapacitated Child is amended to require proof of continued incapacity not more than once per year.

Waiver of Premium Benefit
If the **Waiver of Premium Benefit** is included, the timeframe to provide proof of Total Disability is amended to extend to no later than 180 days after the date of Total Disability. The extension of 180 days also applies to providing proof after requested.

General Exclusions and Limitations
The exclusion for cosmetic or elective surgery is amended to allow coverage when cosmetic surgery is performed on a child to correct a congenital defect or anomaly.

Claim Provisions
Notice of Claim is amended to allow that written notice of a claim may also be given to Our authorized agent.

Proof of Claim is amended to extend the timeframe in which written proof of claim must be filed, to 180 days.

Time of Claim Payment is added:

Time of Claim Payment: Benefits for loss covered by the Policy are paid upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.

NORTH DAKOTA

Residents of the state of North Dakota, the following provisions are included to bring your Certificate into conformity with North Dakota state law:

The Covered Person will have 10 days to review this Certificate. If the Covered Person is not satisfied for any reason, he may send the Certificate back to Us within 10 days of its delivery. In that event, We will consider it void and refund all premium paid by the Covered Person.

General Definitions
If Dependent coverage is included, the definition of **Child** includes a child of a Dependent.

If Dependent coverage is included and **Eligible Student** is defined, the restriction of not being in the armed forces is removed.

Mental and Nervous Disorder Treatment Benefit (Inpatient)/Drug and Alcohol Treatment Benefit (Inpatient)
If the **Mental and Nervous Disorder Treatment Benefit (Inpatient)** and/or **Drug and Alcohol Treatment Benefit (Inpatient)** are included, mental health and substance abuse must be covered as any other illness, therefore any references to, limitations of, or restrictions applied to:

- Mental and Nervous Disorder Treatment Benefit (Inpatient), Drug and Alcohol Treatment Benefit (Inpatient), and
- a Residential Treatment Facility, with respect to the Mental and Nervous Disorder Treatment Benefit (Inpatient) and Drug and Alcohol Treatment Benefit (Inpatient), and
- a place for the Treatment of Mental and Nervous Disorders, alcoholism or drug addiction, and
- a place for the care of drug addicts, alcoholics, or the mentally ill, and
- treatment for drug and alcohol addictions,

are removed.

Surgery Benefit (Inpatient)/Surgery Benefit (Outpatient)
If the **Surgery Benefit** (Inpatient) and/or **Surgery Benefit** (Outpatient) are included, the limitation that the Surgery occur within a specified time period of the Injury or Sickness is removed.

Transportation Benefit
If the **Transportation Benefit** is included, the limitation that the Hospital Confinement occur within a specified time period of the Injury or Sickness is removed.

Continuation and Reinstatement Provisions
Extension of Benefits for Disability is added:

Extension of Benefits for Disability: If the Policy cancels while the Covered Person is disabled and entitled to benefits, the benefits:

1. will continue as long as he remains disabled by the same disability; but
2. will not continue beyond the earlier of:
   a. the date benefits would have ceased had the insurance remained in force; or
   b. the last day of a period of 12 consecutive months following the date the Policy canceled.

General Exclusions and Limitations
The following exclusions are not applicable (if included in your Certificate):

- use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
- Mental and Nervous Disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;

OKLAHOMA

Residents of the state of Oklahoma, the following provisions are included to bring your Certificate into conformity with Oklahoma state law:

The following disclosures are included: (reference to Dependent only applies if Dependent coverage is included): Certificates delivered in the state of Oklahoma are subject to the terms and conditions of the Certificate and not the Policy. This Certificate is issued in and governed by the laws of the state of Oklahoma. The benefits described in this Certificate insure the Covered Person and, if applicable, Dependents, provided the person is eligible, has become covered, and the required premium has been paid to Us.

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Eligibility, Effective Date and Termination Provisions

If Dependent coverage is included, the **Newborn Child Provision** is amended to indicate that the Covered Person's Newborn Child will become covered by the Policy from the moment of "birth" rather than "live birth".

General Exclusions and Limitations

The act of war exclusion is amended to include "when serving in the military or an auxiliary unit."

Claim Provisions

Overpayment of Claim is amended to limit the recovery period to 24 months unless it is a case of claimant fraud.

Time of Claim Payment is added:

Time of Claim Payment: Benefits for loss covered by the Policy are paid upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.

TEXAS

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first 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.

UnitedHealthcare Insurance Company

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

Call: UnitedHealthcare Insurance Company
Toll-free: 1-866-615-8727
Mail: United HealthCare Insurance Company Administrative Offices
9900 Bren Road East, Minnetonka. MN 55343

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

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

Llame a: UnitedHealthcare Insurance Company
Teléfono gratuito: 1-866-615-8727
Dirección postal: United HealthCare Insurance Company Administrative Offices,
9900 Bren Road East, Minnetonka. MN 55343

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP,
Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

07/2023

Claim Provisions
Time of Claim Payment is added:

Time of Claim Payment: Benefits for loss covered by the Policy are paid upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.

VERMONT

Residents of the state of Vermont, the following provision is included to bring your Certificate into conformity with Vermont state law:

Vermont Mandatory Civil Union

Purpose: Vermont law requires coverage for parties to a civil union equivalent to that provided married persons. If any terms of the Policy would not be equivalent, the terms are hereby amended to comply. As used in this Notice, Civil Union means one established according to Vermont law.

Definitions, Terms, Conditions and Provisions: In Vermont, the word Spouse, as used in the Policy includes a person with whom the Covered Person has received a Certificate of Civil Union under Vermont law. Any terms that refer to a marital relationship such as "marriage," "spouse," "relative," "beneficiary," "survivor," "immediate family," and any other such terms includes the relationship created by a Civil Union.

Terms that refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree," "termination of marriage," and any other such terms include the inception or dissolution of a Civil Union.

Terms that refer to a family relationship arising from a marriage such as "family," "immediate family," "dependent," "children," "relative," "beneficiary." "survivor" and any other such terms include the family relationship created by a Civil Union. A child born or brought to a Civil Union will be a Child under the Policy if he meets all other Policy criteria to qualify under the definition of Child.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE: Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, under federal law, the Employee Income Retirement Security Act of 1974 known as “ERISA,” controls the employer /employee relationship with regard to determining eligibility for enrollment in private employer health insurance plans. Because of ERISA, Act 91 of Vermont state law does not state requirements pertaining to a private employer’s enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a Civil Union if the public employer provides such coverage to the dependents of married persons. Federal law also controls group health insurance continuation rights under “COBRA” for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under a Policy or Certificate that derive from federal law. You are advised to seek expert advice to determine your rights under the Policy.

UHICI-CIVUNION-VT

WASHINGTON

Residents of the state of Washington, the following provision is included to bring your Certificate into conformity with Washington state law:

The following Outline of Coverage is included: UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, Connecticut
(Home Office)

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure provides a very brief description of the important features of the coverage being considered. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both the master policyholder and UnitedHealthcare Insurance Company.

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), you should check with your tax advisor or benefit advisor prior to purchasing this coverage to be sure that you will continue to be eligible to contribute to the HSA if this coverage is purchased.

The benefits under this policy are summarized below:

Type of Coverage: Hospital Confinement Indemnity Insurance Coverage. Hospital confinement indemnity coverage pays you a fixed dollar amount during or resulting from periods of hospitalization resulting from a covered injury or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the benefits described below. The certificate does NOT provide general health insurance.

Covered Benefits- Option 1	**Daily Benefit Amount**
Hospital Admission Benefit	$500
Daily Hospital Confinement Benefit	$100
Daily Intensive Care Unit Confinement Benefit	$100
Intensive Care Unit Admission Benefit	$500
Covered Benefits- Option 2	**Daily Benefit Amount**
Hospital Admission Benefit	$1,000
Daily Hospital Confinement Benefit	$150
Daily Intensive Care Unit Confinement Benefit	$150
Intensive Care Unit Admission Benefit	$1,000

Covered Benefits- Option 3	**Daily Benefit Amount**
Hospital Admission Benefit	$1,500
Daily Hospital Confinement Benefit	$200
Daily Intensive Care Unit Confinement Benefit	$200
Intensive Care Unit Admission Benefit	$1,500

Benefit Trigger: The coverage pays you or your Dependent, if applicable, the Daily Benefit Amount for each Benefit shown on the Certificate Schedule, subject to all the terms, limits, and exclusions of the policy.

Duration of Coverage: Your coverage terminates on the first to occur of: the last day of the period for which premium is paid; the last day of the month during which you enter active duty of the armed forces; the last day of the month during which you cease to be in a class eligible for coverage; the date the Policy terminates; the date a benefit shown on the Schedule of Benefits is paid to you; or the date you cease to be actively at work.

Your dependent's coverage will terminate when you are in a class that is no longer eligible for dependent coverage or if the dependent no longer meets the definition of a dependent as explained in the certificate. Coverage may be continued for children who reach the age limit and are incapacitated on that date.

In certain cases insurance may be continued as stated in the section of the Certificate titled ***CONTINUATION, AND REINSTATEMENT PROVISIONS***.

Renewability of Coverage: The Policy will continue in force until it is canceled by either the Policyholder or UnitedHealthcare Insurance Company.

Policy provisions that exclude, eliminate, restrict, limit, delay, or in any other manner operate to qualify payment of the benefits described above include the following:

We will not cover any loss caused by or resulting from (directly or indirectly):

1. an act or Accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any loss which is intentionally self-inflicted;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician, this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
7. Treatment received outside the United States or its territories;
8. the reversal of a tubal ligation or vasectomy;
9. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician services, unless required by law;
10. participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
11. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
12. driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway;
13. Mental and Nervous Disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;
14. dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an Injury; or (b) correct a disorder of normal bodily function; and
15. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

General Definitions

If Dependent coverage is included and **Eligible Student** is defined, the restriction of not being married is removed.

If Dependent coverage is included and **Domestic Partner** is defined, it is amended to always include both opposite or same sex.

Eligibility, Effective Date and Termination Provision

If Dependent coverage is included, the **Newborn Child Provision** is amended to allow 61 days to submit written request of a newborn's enrollment.

General Exclusions and Limitations

The following exclusion is not applicable (if included in your Certificate):

- use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy.

The act of war exclusion is replaced with "due to war or act of war, whether declared or undeclared.'

This provision applies only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

STATEMENT OF EMPLOYEE ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this description of the Plan.

You may examine, without charge, all Plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions and other documents filed with the Department of Labor. You can examine copies of these documents in the Plan Administrator's office or at other specified locations, or you can ask your supervisor where copies of the documents are available.

If you want a personal copy of Plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of these copies.

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

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These individuals, called "fiduciaries," have an obligation to administer the Plan prudently and to act in the interest of Plan participants and beneficiaries. The named fiduciary for this Plan is the Plan Sponsor. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court provided you have exhausted the procedures and complied with the timeframes for review of the adverse claim decision provided below. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, United States 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.

CLAIMS DENIAL FOR HOSPITAL INDEMNITY INSURANCE

Notice of a decision to deny a claim (in whole or in part) shall be furnished to the claimant within 45 days following the receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the expiration of the initial 45 day period.

The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim is expected to be furnished. If a claim is denied (in whole or in part) notice shall be provided to the claimant in writing and shall set forth: 1) the reason(s) for the denial; 2) reference to the provision(s) of the Plan on which the denial is based; 3) a description of any additional material or information necessary for the claimant to perfect the claim, if the claim was denied because the claimant failed to provide all necessary information, and an explanation of why such material or information is necessary; and 4) an explanation of the claim review procedure. If written notice of the denial is not furnished to the claimant within 45 days (or if an extension was required, 105 days) from the date the claim was received, the claim shall be deemed denied and the claimant shall then be permitted to proceed with the procedure set forth below.

REVIEW OF DENIED CLAIMS AND COMPLAINT PROCEDURE FOR HOSPITAL INDEMNITY INSURANCE

If a covered person or any person claiming through a covered person wishes to have a denied claim reviewed, a written request must be sent to the address identified in the claim denial letter.

Any complaint or dispute related to review of denied claims shall be resolved in accordance with the procedure set forth by the Plan Sponsor and outlined below.

1. The complainant may contact the Insurance Carrier's service representative in an attempt to resolve the complaint in an informal manner.
2. If the complainant is not satisfied with any attempts at informal resolution, the complainant must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the address identified on the claim denial letter within 180 days of receipt of the claim denial notice. The complainant may submit supporting documentation or information to be considered. The complainant must submit any requested additional information or documents.
3. A written notice of the final decision will usually be sent to the complainant within 45 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 45 day period, but no later than 90 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the complainant prior to the expiration of the initial 45 day period. The written notice of the final decision will give specific reason(s) for the decision and references to the provision(s) of the Plan on which the decision is based. If the final written decision is not furnished to the complainant within 45 days (or if an extension was required, 90 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review.