

**HCC LIFE INSURANCE COMPANY**

225 TownPark Drive, Suite 350  
Kennesaw, Georgia 30144  
800-447-0460

**GROUP SUPPLEMENTAL MEDICAL EXPENSE INSURANCE**

**CERTIFICATE OF INSURANCE**

HCC Life Insurance Company has issued a Policy covering certain Eligible Classes of the Policyholder. The Benefits of the Policy are described in this Certificate and Your Schedule of Benefits. Final interpretation is governed by the Policy. You may review the Policy at the Policyholder's address during normal business hours. This Certificate replaces any and all Certificates previously issued for the Eligible Classes under the Policy. This Certificate describes the Policy in detail.

**NOTICE CONCERNING YOUR CERTIFICATE**

The Benefits and provisions of the Policy are described in this Certificate. This Certificate of Insurance provides limited benefits and it not intended to cover all medical expenses. PLEASE READ THIS CERTIFICATE OF INSURANCE CAREFULLY.

**IMPORTANT NOTICE:** Benefits are payable only for listed Covered Procedures that were both started and completed while the patient is insured under the Policy, and after any applicable Eligibility Waiting Periods have been served.

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person who Claims rights or Benefits under the Policy.

Signed for HCC Life Insurance Company

  
\_\_\_\_\_  
President

  
\_\_\_\_\_  
Corporate Secretary

**THIS IS LIMITED BENEFIT INSURANCE  
THIS IS NOT MAJOR MEDICAL INSURANCE**

**THIS IS SUPPLEMENTAL MEDICAL EXPENSE COVERAGE TO THE POLICYHOLDER'S PRIMARY HEALTH BENEFIT PLAN. IT PAYS LIMITED BENEFITS FOR HOSPITAL CONFINEMENTS, CERTAIN OUTPATIENT EXPENSES, AND PRESCRIPTION DRUG EXPENSES OTHERWISE COVERED UNDER THE POLICYHOLDER'S PRIMARY HEALTH BENEFIT PLAN, BUT NOT PAYABLE DUE TO THE DEDUCTIBLE AND COINSURANCE PROVISIONS OF THAT PLAN. THIS IS NOT WORKER'S COMPENSATION INSURANCE.**

**TABLE OF CONTENTS**

SCHEDULE OF BENEFITS ..... 3

GENERAL DEFINITIONS ..... 4

WHEN COVERAGE BEGINS AND ENDS ..... 8

Who is eligible? ..... 8

When do You enroll? ..... 8

When will Your Coverage begin? ..... 9

When will Coverage begin for Your Dependents? ..... 9

When will Your Coverage end? ..... 9

When will Coverage end for Your Dependent? ..... 10

Will Benefits be extended beyond the termination date for any reason? ..... 11

Continuation of Coverage during a Labor Dispute ..... 11

COVERAGE PROVISIONS ..... 11

What Benefits are provided to Covered Persons? ..... 11

Inpatient Hospital Benefit ..... 11

Outpatient Benefit. .... 11

Physician Office Visit Benefit. .... 12

Prescription Drug Benefit. .... 12

Is there a Plan Year Benefit Maximum? ..... 12

CONTINUATION OF COVERAGE ..... 12

COBRA (Consolidated Omnibus Budget Reconciliation Act) ..... 12

State Law Continuation ..... 14

CLAIMS PROVISIONS ..... 14

Submitting Claims and Receiving Reimbursement ..... 14

How and when to submit a claim: ..... 14

Proof of Loss: ..... 15

What if additional information is required? ..... 15

When will the Claim be paid? ..... 15

What if there is an overpayment of Benefits? ..... 15

Payment to Conservator Other Than Group Member ..... 15

COMPLAINT AND APPEAL PROCEDURES ..... 16

What if You have questions about your Benefits or Claim payments? ..... 16

What if You don't agree with a Claim denial? ..... 16

EXCLUSIONS ..... 16

GENERAL PROVISIONS ..... 17

Absence of Other Medical Plan: ..... 17

Assignment ..... 17

Changes to Policy ..... 17

Incontestability - Time Limit on Certain Defenses ..... 17

Errors ..... 18

Legal Actions ..... 18

Misrepresentation ..... 18

Misstatement of Age or Fact ..... 18

Notice to Policyholder ..... 18

Workers' Compensation Not Affected ..... 18

**SCHEDULE OF BENEFITS**

**Alabama Road Builders Association Health Trust Policy #HCCMP251721**

Effective Date of Coverage: 01/01/2025

Policy Deductible	per covered	\$500
	per family	\$1,000
Hospital Inpatient/Outpatient Benefit	per covered	\$4,500
	per family	\$9,000
Prescription Drug Benefit		Not Included
Policy Coinsurance/Copayment		100%
Physician Office Visit Benefit		Not Included
Primary Health Benefit Plan Deductible		\$5,000
Primary Health Benefit Plan Out of Pocket		\$7,000
Primary Health Benefit Plan Coinsurance		80%
Non-Insurance Benefits: Telemedicine/Advocacy		Not Included

Maximum Combined Benefit Per Calendar Year	\$4,500 per Covered Person \$9,000 all Covered Persons
Eligibility Waiting Period	The Policy follows the same waiting period as the underlying Primary Health Benefit Plan. If the underlying Primary Health Benefit Plan has no waiting period, the Policy has no waiting period.
Deductible Credit	N/A
<b><u>Benefit Description</u></b>	<b><u>Benefit Amount and Limitations</u></b>
In-Hospital Services	Subject to Maximum Combined Benefit per Calendar Year
Outpatient Services	Subject to Maximum Combined Benefit per Calendar Year
Prescription Drugs	Subject to Maximum Combined Benefit per Calendar Year
The Policy pays 100% of eligible charges allowed under the Primary Health Benefit Plan Deductible and Coinsurance provisions, up to the Maximum Combined Benefit, stated above. Charges which are not allowed by the Primary Health Benefit Plan will not be covered by the Policy. <i>Contains no pre-existing condition exclusion period.</i>	

## GENERAL DEFINITIONS

Accident: A specific unforeseen event:

1. that is sudden, unexpected, and unintended, over which a Covered Person has no control; and
2. which directly, and from no other cause, results in an Injury; and
3. that is independent from Sickness, disease, bodily infirmity, or illness.

Actively at Work: As defined by Policyholder.

Benefit: The dollar amount payable by Us to a Claimant or assignee under the Policy.

Calendar Year: For the first year is the period of time that begins on the Effective Date and ends on December 31. For subsequent years, it is the period of time that begins on January 1 and ends December 31. The Effective Date is shown in Your Schedule of Benefits.

Cancer: The autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body.

Cancer Treatment: The treatment of Cancer at a Cancer Treatment Facility. It does not include supplies or drugs recommended or purchased for use outside of the Cancer Treatment Facility, or routine visits designed to diagnose or prevent the reoccurrence of Cancer.

Cancer Treatment Facility: A facility where the treatment of Cancer is provided on an outpatient basis. This also includes an oncologist's office and a Physician's Office.

Certificate: This document that provides a description of the Coverage available under the Policy.

Child or Children: See definition of Eligible Dependent.

Claim: A request for payment of covered Benefits.

Claimant: A person who has filed a Claim for Benefits under the Policy, as an Insured Person or as the dependent of an Insured Person.

Coinsurance/Copayment: The amount of Covered Charges, other than the Deductible, to be paid by the Insured Person under the Policy. The Coinsurance/Copayment is listed in the Schedule of Benefits.

Company: HCC Life Insurance Company. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy: Any of the following:

1. a condition that, while affected by pregnancy, is still classified by accepted medical standards as a Sickness apart from the normal bodily changes that accompany pregnancy;
2. a non-elective cesarean section;
3. an extra uterine or ectopic pregnancy; or
4. a spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

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

Coverage: The right of the Covered Person to receive Benefits subject to the terms, conditions, limitations and exclusions of the Policy.

Covered Charge: Those expenses described in the Policy that are payable under both the Policy and the Covered Person's Primary Health Benefit Plan. Expenses that are excluded under either the Policy or the Covered Person's Primary Health Benefit Plan are not Covered Charges.

Covered Dependent: Your Eligible Dependent who is insured under the Policy.

Covered Person: You and Your Eligible Dependents whom You have enrolled for insurance and paid any Premium due under the Policy.

Deductible: The amount of Covered Charges that must be paid in full by You each Plan Year for each Covered Person (or to the maximum per family limit, when applicable) before any Benefits are payable by Us. The Deductible is listed in the Schedule of Benefits.

Deductible Credit: Allowance given for a Covered Person's Covered Charges under the Primary Health Benefit Plan during the period of time listed in the Schedule of Benefits.

Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. For at least 12 consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, are and have been each other's sole Domestic Partner and have maintained the same principal place of residence; and
2. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and
3. You and Your Domestic Partner have filed a Domestic Partner affidavit with Us; and
4. You and Your Domestic Partner are not legally married to anyone else.

Effective Date: The date on which insurance Coverage begins under the Policy.

Eligibility Waiting Period: The period of time that must pass before an individual becomes eligible to be covered for benefits under the Primary Health Benefit Plan.

Eligible Class: A group of people who are eligible for Coverage under the Policy, as defined by the Policyholder and listed on the Application.

Eligible Dependent: Includes:

1. Your Spouse (if not divorced from You) or Domestic Partner;
2. Your unwed natural Children from the moment of birth, stepchildren, adopted children (child is considered to be Your child if You are a party to a suit in which You seek to adopt the child), children appointed to Your custody by a court order, or foster children until the Child attains age 26; and
3. Grandchildren shall be eligible for coverage if the grandchild is:
  - a. unwed;
  - b. younger than 26 years of age; and
  - c. a dependent of the insured person for federal income tax purposes at the time the application for coverage under the Policy of the grandchild is made.

Coverage of the grandchild will not be terminated solely because the grandchild is not a covered dependent of the insured person for federal income tax purposes

4. A child for whom the Insured Person must provide medical support under a court order. Eligible Dependent Children include natural children, stepchildren, adopted children, grandchildren, children Placed for Adoption, children appointed to Your custody by a court order, or foster children who are dependent upon You for support. Adopted children include a Child where an Eligible Person has the assumption and retention of a legal obligation in anticipation of the adoption of the Child.

On the date the court ordered custody or legal obligation terminates, the Child is no longer considered an Eligible Dependent.

The term Eligible Dependent does not include any person who:

1. is in full-time active duty in the armed forces of any country or international authority; or
2. lives outside of the United States; or
3. is an Insured Person under the Policy.

**Eligible Person:** A person who belongs to an Eligible Class, as defined by the Policyholder.

**Enrollment Form:** The document completed by You in electing Coverage under the Policyholder's Policy.

**Family Member:** A person who is related to the Covered Person in any of the following ways: Spouse, Domestic Partner, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or Child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person's household.

**Freestanding Outpatient Surgery Center:** A freestanding facility where surgical and diagnostic services are provided on an ambulatory basis. It does not include a Physician's Office.

**Full-Time:** A regular workweek as defined by the Policyholder. We have the right to verify the hours worked by reviewing payroll records and/or income tax records.

**Group:** A Policyholder or entity who has entered into a contract with Us to provide Coverage under the Policy.

**Hospital:** An institution that meets all the following requirements:

1. it must be operated according to law;
2. it must give 24-hour medical care, diagnosis and treatment to the sick or injured on an inpatient basis;
3. it must provide diagnostic and surgical facilities supervised by Physicians;
4. Registered Nurses must be on 24-hour call or duty; and
5. the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Hospital does not mean a convalescent, nursing, rest or extended care facility or a facility operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facility is operated as a separate institution by a Hospital.

**Hospital Emergency Room:** A portion of a Hospital where emergency diagnosis and treatment of Sickness or Injury due to an Accident is provided.

**Hospital Outpatient Facility:** An area contained within a Hospital building that is owned and operated by the Hospital and not otherwise excluded under the terms of the Policy where patients receive diagnostic testing or treatment without being admitted to the Hospital on an Inpatient basis.

**Injury:** Bodily injury sustained directly and independently of all other causes, which results in loss covered by the Policy.

**Inpatient:** The Covered Person is a registered bed patient in a Hospital for more than 18 continuous hours and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician.

**Insured Person:** A person who is an Eligible Person, who has qualified for insurance by completing the Eligibility Waiting Period, and for whom insurance under the Policy has become effective.

**Late Entrant:** A person who applies for coverage under the Policy more than 31 days after he or she initially becomes eligible.

**Leave of Absence:** An arrangement where You and the Policyholder agree that You will not be Actively at Work for a specific period of time and You are expected to be Actively at Work at the end of that period. Refer to When Your Coverage Begins and Ends to determine how long Your Coverage can be continued during a Leave of Absence.

**Magnetic Resonance Imaging (MRI) Facility:** A freestanding diagnostic imaging facility that provides

diagnostic testing using magnetic resonance imaging.

Outpatient: The Covered Person is not an Inpatient when covered services are received.

Part-Time: A schedule of work defined as part-time by the Policyholder. We have the right to verify the hours worked by reviewing payroll records and/or income tax records.

Physical Therapy: The treatment of physical dysfunction or Injury, at a Physical Therapy Facility, by the use of therapeutic exercise and the application of modalities, intended to restore or facilitate normal function or development. Physical Therapy does not include kinesiology, speech or occupational therapy, or equipment recommended, used or purchased for use outside of the Physical Therapy Facility.

Physical Therapy Facility: An office, center or clinic in which a licensed physical therapist provides Physical Therapy.

Physician: means a person licensed by the state in which he or she is a resident to practice the healing arts. He or she must be practicing within the scope of his or her license for the service or treatment given. He or she may not be the Insured Person or a Family Member.

Physician's Office: The location in which a Physician routinely, on an appointment basis, provides health examinations, diagnosis and treatment of Sickness or Injury due to an Accident on an ambulatory basis. It does not include a Hospital, Freestanding Outpatient Surgery Center or Urgent Care Facility.

Placement for Adoption; Placed for Adoption: A Child is placed in Your physical custody for the purpose of adoption.

Plan Year: The period of time shown in the Schedule of Benefits as Calendar Year or Policy Year.

Policy: The agreement between Us and the Policyholder which states the terms, conditions, limitations, and the exclusions regarding Coverage.

Policy Anniversary: The month and day as shown in the Policy as the Policy Anniversary.

Policy Year: For the first year, is the period of time that begins on the Effective Date and ends on the day before the next following Policy Anniversary. For subsequent years, it is the period of time that begins on the first and each subsequent Policy Anniversary and ends on the day before the next Policy Anniversary. The Effective Date is shown in Your Schedule of Benefits.

Policyholder: The organization named in the Policy and Schedule of Benefits who has contracted with us to provide benefits to You.

Premium: The periodic fee required to maintain Coverage for each Eligible Person and Dependent in accordance with the terms of the Policy.

Prescription Drug: A medicine that can be purchased or given out only with written instructions from a licensed healthcare provider.

Primary Health Benefit Plan: Any major medical or comprehensive medical plan offered by the Policyholder through which a Covered Person has coverage. It may be a self-funded plan or provided through insurance. Primary Health Benefit Plan does not include any limited medical program, Medicare, Medicaid, CHAMPUS, or TRICARE.

Prior Plan: The plan providing similar insurance Benefits carried by the Policyholder on the day before the Policy's Effective Date with Us.

Regular and Customary Activities: Means: 1) for the working Covered Person, he or she is actively performing all the duties of his or her regular occupation; and 2) for a non-working dependent, he or she is

regularly performing the normal activities of a person of like age and good health.

Schedule of Benefits: This document shows You the amount of Benefits provided under the Policy.

Sickness: A bodily disorder, disease or illness, including Complications of Pregnancy.

Sign or Signed: The use by a person of a symbol or method with the present intention to authenticate a record. Such authentication may be executed and/or transmitted by paper or electronic media, provided it is acceptable to Us and consistent with applicable law.

Spouse: Your lawful Spouse who is an Eligible Dependent.

Takeover Benefit: The major medical or comprehensive medical plan through which an Eligible Person and their Eligible Dependents continues their Primary Health Benefit Plan Coverage as defined under COBRA.

Total Disability/Totally Disabled: Due Injury or Sickness, the Covered Person cannot perform the Covered Person's Regular and Customary Activities. The loss of a professional or occupational license for any reason does not, in itself, constitute Total Disability.

Urgent Care: Necessary medical intervention that is required for a Sickness or Injury that would not result in further disability or death if not treated immediately, but requires professional attention and has the potential to develop such a threat if treatment is delayed longer than 24 hours.

Urgent Care Facility: A medical facility or clinic where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate Urgent Care. It does not include a Physician's Office.

We, Us, Our, and Insurer: Means HCC Life Insurance Company.

Written or Writing: A record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and Your: Refers to an Insured Person.

Other terms are defined elsewhere under the Certificate.

## **WHEN COVERAGE BEGINS AND ENDS**

### **Who is eligible?**

Eligible Person: An individual is eligible for Coverage if he or she is covered under a Primary Health Benefit Plan and in an Eligible Class as defined by the Policyholder and if he or she satisfies any Eligibility Waiting Period as defined by the Policyholder.

Eligible Dependent: Your Eligible Dependents are also eligible for Coverage, provided that he or she is covered under a Primary Health Benefit Plan, You are insured under the Policy and that Dependent Coverage is provided under the Policy.

Dual Eligibility Status: If both an Eligible Person and his or her Spouse or Domestic Partner are in an Eligible Class of the Policyholder, each may enroll individually or as a Dependent of the other, but not as both. Any Eligible Dependent Child may also only be enrolled by one parent/guardian. If the Spouse or Domestic Partner carrying dependent Coverage ceases to be eligible, please notify Us immediately. Dependent Coverage then becomes effective under the other Spouse's or Domestic Partner's Coverage.

### **When do You enroll?**

Enrollment is when an Eligible Person completes an Enrollment Form giving the information We require. As the Eligible Person, if You are required to pay all or part of the Premium for Coverage, You must acknowledge Your permission to the Policyholder to withhold such Premium from Your Pay. The enrollment for Coverage may be written or electronic on an Enrollment Form furnished or approved by Us.



**Eligible Person:** An Eligible Person who has met all eligibility requirements of the Policyholder may enroll at any time throughout the Plan Year. The Enrollment Form must be completed and Signed on or before the desired Effective Date of Coverage.

**Eligible Dependent:** If the Policy provides for Dependent Coverage, an Eligible Person may request enrollment of his or her Dependents at the time he or she requests enrollment for himself per the above. If Eligible Dependents are not enrolled at this time, the Dependent may not enroll until the next annual Enrollment Period.

**Enrollment Period:** The Policyholder may provide for an Enrollment Period during the Policy Year. Eligible Persons may enroll themselves and their Eligible Dependents during an Enrollment Period, as if they were a newly Eligible Person.

### **When will Your Coverage begin?**

If the Policyholder requires You to contribute toward the cost of all or part of the insurance, such insurance will not become effective for You before You agree to make the required contributions and the first Premium is paid. The form may be obtained from the Policyholder. Insurance will not be effective to You before the first Premium is paid.

Subject to Your enrollment and payment of any Premium due, insurance is effective at 12:01 AM at the main office of the Policyholder on Your first day of Coverage:

1. The first of the month following the date an Eligible Person enrolls if an Eligible Person enrolls for Coverage after the Policy Effective Date.

Notwithstanding the above, if You are not Actively at Work on the date Your insurance Coverage would begin, Your insurance will begin on the date You come back to Active Work.

### **When will Coverage begin for Your Dependents?**

Subject to the enrollment procedure described above and payment of the Premium due, Your Dependents will become insured on the same date and at the same time as You. If You acquire additional Dependents after Your Effective Date of Coverage and have Dependent Coverage, and provided You enroll Your Eligible Dependents as indicated above, the Effective Date of the newly acquired Dependents will be the date We accept the new enrollment, subject to timely payment of any Premium due.

If You acquire additional Dependents after Your Effective Date of Coverage and do not have Dependent Coverage, and provided You enroll Your newly Eligible Dependents as indicated above, the Effective Date will be:

1. for Your Spouse or Domestic Partner, the first of the month following the event causing eligibility;
2. for all other Eligible Dependents, the first of the month following the date You enroll such Dependent; subject to payment of any Premium due. If Your Dependent is enrolled as a result of a court or administrative order, Coverage for such child shall take effect on the first of the month following the date of the order, if We are notified in accordance with our enrollment guidelines once the required Premium, if any, has been paid.

### **When will Your Coverage end?**

All of Your insurance under the Policy will terminate at 12:01 AM at the main office of the Policyholder on the earliest of the following dates:

1. The date Your employment terminates. For the purposes of insurance coverage Your employment will terminate when You are no longer Actively at Work;
2. The date the Policy terminates or Coverage under Your Primary Health Benefit Plan terminates;
3. The date Your employer ceases to be an Affiliated company with the Policyholder;
4. The date You cease to be an Eligible Person, except due to a Leave of Absence;
5. The date specified by Us in written notice to You that Your Coverage ends due to fraud or misrepresentation;
6. The date We receive written notice from You or the Policyholder telling Us to terminate Coverage of a Covered Person or the date requested in that notice, whichever is later;

7. The last day of the period for which Premium was paid, if a Premium is not paid when due subject to the Grace Period provision;
8. The date the Policy is changed to end the insurance for Your Eligible Class;
9. The date You retire unless Your insurance is continued in a retired Eligible Class as defined by the Policyholder;
10. For retirees, the date Your status as a retiree ends in accordance with the Policyholder's retirement plan;
11. The date You enter full-time active duty in the armed forces of any country, We will refund the unearned pro-rata Premium to such person upon request;
12. The last day of the month following Your 70th birthday;
13. The date of Your death.

In addition, Coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder.

#### **When will Coverage end for Your Dependent?**

Your Dependent's insurance under the Policy will terminate at 12:01 AM at the main office of the Policyholder on the earliest of the following dates:

1. The date the Policy terminates or Coverage under Your Primary Health Benefit Plan terminates;
2. The last day of the month the Dependent ceases to be an Eligible Dependent;
3. The date You cease to be insured under the Policy;
4. The date You cease to be in an Eligible Class for Dependent Coverage;
5. The last day of the period for which Premium was paid, if a Premium is not paid when due subject to the Grace Period provision;
6. The last day of the month We receive written notice from You or the Policyholder telling Us to terminate Coverage on any Dependent or the date requested in that notice, whichever is later;
7. The date the Policy is changed to end the insurance for Your Eligible Class;
8. The date that the Dependent enters full-time active duty in the armed forces of any country or international authority;
9. For Your Dependent Spouse or Domestic Partner the last day of the month following Their 70th birthday;
10. The date of Your death, unless Benefits are extended under the "Will Benefits be extended beyond the termination date for any reason?" provision noted below.

#### **Handicapped Dependent Children:**

A handicapped Dependent Child who is not capable of supporting himself or herself due to mental incapacity or physical handicap will be continued beyond the age at which Coverage would otherwise have terminated if:

1. The Dependent child became incapacitated prior to the age at which Coverage would otherwise have terminated; and
2. The Dependent child is primarily Dependent on the Eligible Person for support and maintenance; and
3. Proof of such incapacity and dependence is given to Us by a Doctor within 31 days of the date the child reaches the limiting age. Proof must also be given to Us annually thereafter. Failure to provide such proof within 31 days of Our request will result in the termination of the Dependent child's Coverage under the Policy.

Coverage will continue as long as the Dependent continues to be so incapacitated and Dependent, unless otherwise terminated in accordance with the terms of the Policy.

**Notice Required When Your Coverage Terminates:** We must be informed within 30 days of the date Your Coverage terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above. In the event Premiums have been paid to Us on Your behalf after Your Coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up to a maximum of 3 Policy months or to the last Policy Anniversary, whichever is less. If We are not notified that Your Coverage is terminated and We pay any Benefits for Your Covered Expenses incurred after the date Your Coverage terminated, You will be responsible for payment

of all Premiums due through the Policy month in which Benefits were paid.

**Will Benefits be extended beyond the termination date for any reason?**

This provision applies if a Covered Person is Hospital confined or Totally Disabled on the termination date of the Policy, unless termination is due to nonpayment of Premiums. The Company will pay the same benefits for the duration of any Hospital confinement or Total Disability, or 90 days thereafter, whichever occurs first, if:

1. the Covered Person has incurred Covered Charges before the termination date; and
2. any Hospital confinement or Total Disability begins before the termination date. No further Premium payment is required to qualify for this extension of benefits.

This provision will not apply if coverage under the Covered Person's Primary Health Benefit Plan terminates and the Primary Health Benefit Plan does not have a similar extension of benefits provision.

**Continuation of Coverage during a Labor Dispute**

If You stop work because of a labor dispute, coverage continues under the Policy, upon timely payment of Premium if You:

1. are covered under the Policy on the date the work stoppage begins;
2. continue to pay Your individual contribution; and
3. assume and pay during the work stoppage the contribution due from the employer.

Continuation ends at the earliest of the following dates:

1. 6 months after a work stoppage occurs;
2. the date when 75% of the Insured Persons continue the coverage;
3. the date You take a full-time job with another employer; or
4. the date the Policy is terminated.

**COVERAGE PROVISIONS**

**What Benefits are provided to Covered Persons?**

The following benefits are payable if the Covered Person is covered by a Primary Health Benefit Plan when the Covered Charges are incurred. Each benefit is subject to the terms, conditions, limitations, exclusions and Plan Year Benefit Maximums as described herein.

**Inpatient Hospital Benefit.** We will pay the Benefit shown in the Schedule of Benefits for Covered Charges incurred by a Covered Person if:

1. the Covered Charges are incurred while the Covered Person is an Inpatient; and
2. after satisfaction of any Deductible shown on the Schedule of Benefits; and
3. with respect to Late Entrants, the Covered Charges are incurred more than 30 days after the Late Entrant's Effective Date.

Benefits payable are limited to:

1. any deductible amount applied to the expenses covered by the Covered Person's Primary Health Benefit Plan; and
2. any coinsurance and/or copayment amount applied to the expenses covered by the Covered Person's Primary Health Benefit Plan.

These Benefits will include any out-of-pocket deductible, copayment, and coinsurance amounts the Covered Person incurs under the Primary Health Benefit Plan due to ground or air ambulance services used for the same event that results in the Covered Person using this Inpatient Hospital Benefit.

The total Benefits payable for each Covered Person during a Plan Year will not exceed the Plan Year Benefit Maximum under the Inpatient Hospital Benefit shown in the Schedule of Benefits.

**Outpatient Benefit.** We will pay the Benefit shown in the Schedule of Benefits for Covered Charges incurred by a Covered Person:

1. after satisfaction of any Deductible shown on the Schedule of Benefits; and
2. subject to the Maximum Combined Benefit shown on the Schedule of Benefits.

Benefits payable under the Policy are limited to any out-of-pocket deductible, copayment, and coinsurance amounts the Covered Person incurs under the Primary Health Benefit Plan for:

1. Outpatient treatment in a Hospital Emergency Room without subsequently being considered an Inpatient; and
2. Outpatient treatment in an Urgent Care Facility; and
3. Cancer Treatment performed in a Cancer Treatment Facility; and
4. Physical Therapy performed in a Physical Therapy Facility; and
5. Outpatient surgery performed in a Hospital Outpatient Facility a Freestanding Outpatient Surgery Center, or Physician's Office; and
6. Outpatient diagnostic testing performed in a Hospital Outpatient Facility, a Magnetic Resonance Imaging (MRI) Facility, or a Physician's Office; and
7. Outpatient treatment performed in a Hospital Outpatient Facility or Physician's Office; and
8. Durable medical equipment when prescribed by a Physician
9. Ground or Air Ambulance services.

**Physician Office Visit Benefit.** We will pay the Benefit shown in the Schedule of Benefits if the Covered Person incurs a Covered Charge as the result of:

1. treatment by a Physician due to Sickness;
2. treatment by a Physician for an Injury due to an Accident; or
3. routine well child examinations and immunizations for Dependent children.

Benefits are only payable if the Covered Charges are incurred while the Covered Person is not an Inpatient.

**Prescription Drug Benefit.** We will pay the Benefit shown in the Schedule of Benefits for covered charges incurred by a Covered Person:

1. after satisfaction of any Deductible shown on the Schedule of Benefits, and
2. subject to the Maximum Combined Benefit shown on the Schedule of Benefits.

#### **Is there a Plan Year Benefit Maximum?**

The Plan Year Benefit Maximum is the maximum benefit payable by the Policy for a Benefit in a Plan Year. This maximum will apply even if a Covered Person's Coverage is interrupted or if a Covered Person has been covered both as an Insured Person and as a Covered Dependent during a Plan Year. The Plan Year Benefit Maximum is listed in the Schedule of Benefits.

### **CONTINUATION OF COVERAGE**

You should contact the Policyholder's plan administrator to determine if You are eligible to continue Coverage under COBRA or under the "State Law Continuation" provision.

#### **COBRA (Consolidated Omnibus Budget Reconciliation Act)**

Continuation Coverage under COBRA: Continuation applies only to Policyholders which are subject to the provisions of COBRA. You should contact the Policyholder's plan administrator to determine if You are eligible to continue Coverage under COBRA or under the "State Law Continuation" provision. We are not obligated to provide continuation Coverage to a Covered Person if the Policyholder or its designated plan administrator fails to perform its duties under federal law. These duties include but are not limited to:

1. notifying the Covered Person in a timely manner of the right to elect continuation Coverage; and
2. notifying Us in a timely manner of the Covered Person's election of continuation Coverage.

We are not the Policyholder's designated plan administrator and do not assume any duties of a plan administrator pursuant to federal law.

If You chose continuation coverage under a Takeover Benefit plan which was replaced by the Policy, Your

continued coverage shall terminate on the first to occur of:

1. the date scheduled under the Prior Plan; or
2. in accordance with the terminating events stated below.

Qualifying Events for COBRA Continuation Coverage: If Your Coverage terminates due to one of the following qualifying events, You are entitled to continue Coverage. You may elect the same Coverage that You had at the time of the qualifying event. Qualifying Events are:

1. Your termination of employment with the Policyholder or reduction of hours, for any reason other than gross misconduct; or
2. Your death; or
3. a Covered Person's divorce; or
4. a Dependent Child's loss of eligibility; or
5. entitlement of the Eligible Person to Medicare benefits; or
6. for You, if retired, and Your Covered Dependents, the filing of Chapter 11 bankruptcy by the Policyholder; or
7. full-time active duty in the armed forces of any country or international authority.

COBRA notification requirements and election period: The Covered Person must notify the Policyholder's designated plan administrator within 60 days of his or her divorce, or loss of eligibility as a Dependent. Continuation must be elected by the later of:

1. 60 days after the qualifying event occurs; or
2. 60 days after You receive notice of the continuation right from the Policyholder's designated plan administrator.

You must pay the initial premium due to the Policyholder's designated plan administrator within 45 days after electing continuation.

Terminating events for COBRA continuation coverage: COBRA continuation under the Policy will end on the earliest of the following dates:

1. 18 months from the date continuation began, if Your Coverage ended because employment was terminated or hours were reduced as described above. If You are disabled at any time during the first 60 days of COBRA coverage, beginning on the day after termination of employment or reduction in hours, continuation Coverage may be extended to a maximum of 29 months. You must give notice of Your disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend Coverage beyond 18 months. If You provide such notice, Your Coverage may be extended up to a maximum of 29 months from the date of such qualifying event or until the first month that begins more than 30 days after the date of any final decision that You are no longer disabled. If You are disabled but have non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29-month disability extension. You must provide notice of any final determination that he or she is no longer disabled within 30 days of such determination;
2. 36 months from the date continuation began for a Dependent whose Coverage ended because of Your death, divorce from You, loss of eligibility by a Dependent Child or entitlement of the Eligible Person to Medicare benefits, in accordance with Qualifying Events described in items 2-6 above;
3. The date Coverage terminates under the Policy for failure to make timely payment of the Premium;
4. The date coverage is obtained under any other Group health plan. If such coverage has a limitation or exclusion with respect to a Covered Person's pre-existing condition, continuation will end on the date such limitation or exclusion ends. The other Group health coverage shall be primary for all health care except health care which is subject to the pre-existing condition limitation or exclusion. If the other Group health plan's pre-existing condition limitations or exclusions cannot be applied because of the restrictions under the Health Insurance Portability and Accountability Act of 1996, then COBRA continuation will end on the date You became covered under the other Group health plan;
5. The date a Covered Person becomes entitled to Medicare, except that this will not apply if the Coverage was terminated because the Policyholder filed for bankruptcy, in accordance with Qualifying Event in item 6 above;
6. The date the Policy terminates; or

7. The date Coverage would otherwise terminate under the Policy.

If Your Coverage ended because employment was terminated or hours reduced as described in item 1 of Qualifying Events and during the 18-month continuation period a second Qualifying Event occurs, Your Coverage may be extended up to a maximum of 36 months. The 36-month period starts from the date Coverage ended due to the first Qualifying Event. If You are entitled to continuation because the Policyholder filed for bankruptcy, as described in item 6 of the Qualifying Events and You, if retired, dies during the continuation period, the Dependents are entitled to continue Coverage for 36 months from the date of death. Terminating events 2-7 above shall apply during any extended continuation period.

A Dependent whose continuation Coverage terminates because the Eligible Person becomes entitled to Medicare should contact the Policyholder's designated plan administrator for information regarding an extension of continuation Coverage for an additional period of time.

### **State Law Continuation**

Eligibility for state continuation coverage: If Your Coverage under the Policy would otherwise terminate due to involuntary termination of employment, You and Your Covered Dependents are entitled to continue Coverage if all the following criteria apply:

1. You were continuously covered under the Policy (or under the Policy and any similar Group plan which was replaced by the Policy) for the entire 3-month period before the termination of employment; and
2. You are entitled to unemployment compensation benefits at the time of the termination of employment; and
3. You are not and do not become covered by or eligible for coverage by Medicare; and
4. You are not and do not become covered under any other Group health plan.

Notification requirements and election period under state law: The Policyholder must notify You of the right to continue Coverage at the time the Policyholder notifies You of the termination of employment.

You must file a written election of continuation with the Policyholder and pay the first month's Premium for continued Coverage no later than:

1. 30 days after the date Your Coverage would otherwise terminate, if the Policyholder notified You of the right of continuation prior to such date; or
2. 30 days after the Policyholder notifies You of the right of continuation, if the notice is given after the date on which Your Coverage would otherwise terminate; or

Terminating events for state continuation coverage: Continuation Coverage under the Policy will end on the earliest of the following dates:

1. The date You cease to be eligible for continuation as described in this provision;
2. 6 months from the date continuation began;
3. The date Coverage terminates under the Policy for Your failure to make timely payment of a required Premium;
4. The date the Policy terminates; or
5. the date Coverage would otherwise terminate under the Policy.

## **CLAIMS PROVISIONS**

### **Submitting Claims and Receiving Reimbursement**

#### **How and when to submit a claim:**

For Covered Persons under an in-force Policy, written notice of claim must be given to Us within 365 days after the date of loss. Upon receipt by Us of the request for claims forms, We will send Claim forms to the Claimant or You. If such forms are not sent to You or the Claimant within 15 days, You or the Claimant will meet the Proof of Loss requirements below if We are given written proof of the nature and extent of the loss.

For Covered Persons under a terminated Policy, except in instances where We have pended a claim received during the Policy Year, in order to be eligible for benefits, any proof of claim incurred during the prior Policy Year must be filed, submitted or otherwise provided to Us within 90 days of the prior Policy's termination date.

**Proof of Loss:** Proof of loss includes a medical claim form and a copy of the Primary Health Benefit Plan's explanation of benefits. We will not deny or reduce any Claim filed after the dates specified in the "How and when to submit a claim" provision above, if:

1. it was not reasonably possible to file the Claim within that period.
2. the Claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us no later than the first anniversary date after it is due, unless You are legally incapable of doing so.

**What if additional information is required?** If the Proof of Loss provided does not contain all necessary information or is not on an appropriate Claim Form, forms for filing Proof of Loss will be sent to the Claimant along with a request for the missing information.

**When will the Claim be paid?** After receiving written Proof of Loss and Premium payment, We will immediately pay all Benefits then due for Covered Charges directly to You or Your Provider. We will notify You in writing of the acceptance or denial of a claim not later than the 15th business day after the date We receive all items, statements, and forms required by Us to secure final proof of loss. If a claim is denied by Us, the notice will state the reasons for the denial. If We are unable to accept or deny the claim within the specified time period, We, within that same period, will notify You of the reasons that We need additional time. We will accept or deny the claim not later than the 45th day after the date We notify You.

All payments made to or by Us will be made in United States dollars.

**What if there is an overpayment of Benefits?** We reserve the right to deduct from any Benefits properly payable under the Policy the amount of any payment that has been made:

1. in error; or
2. pursuant to a misstatement contained in a Proof of Loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under the Policy within 2 years after the date such Coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a Claim for which benefits are recoverable under any policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future Claim for Benefits under the Policy made by a Covered Person if Claim payments previously were made with respect to a Covered Person.

Such deduction shall not be made more than twenty-four (24) months after Benefits are paid with respect to a Covered Person except payment made because of fraud committed by a Covered Person or by a provider; or if the Covered Person or provider has otherwise agreed to make a refund of the claim overpayment.

#### **Payment to Conservator Other Than Group Member**

We may pay benefits on a child's behalf to a person who is not the Insured Person if an order providing for the appointment of a possessory or managing conservator of the child has been issued by a court in the State or Other Jurisdiction of Issue stated in the Policy.

A person who is not an Insured Person is entitled to be paid benefits under the Policy only if the person presents to Us, with the written notice of claim:

1. written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and
2. a certified copy of a court order designating the person as possessory or managing conservator of

the child or other evidence designated by rule of the Insurance Commissioner that the person is eligible for the benefits.

## COMPLAINT AND APPEAL PROCEDURES

### **What if You have questions about your Benefits or Claim payments?**

If You have any questions about Your Benefits, a specific Claim payment, or denial, You should contact Us in writing or by telephone within 30 days.

### **What if You don't agree with a Claim denial?**

If We send You a written statement denying Your Claim in whole or in part, You may submit a written appeal to Us that outlines Your concerns and Your efforts to resolve the matter. The appeal must be filed within 30 days of the receipt of denial. A written decision with respect to the appeal shall be sent to You within 30 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.

Please send to:  
HCC Life Insurance Company  
P.O. Box 2367  
Birmingham, AL 35201

If You are not satisfied by the appeal response or for any reason, You may write to Your State Insurance Department and describe the circumstances and Your complaint.

## EXCLUSIONS

No Benefits are payable under the Policy for the following. In addition, the Charges listed below will not be recognized toward the satisfaction of any Deductible:

1. any expenses incurred during any period the Covered Person does not have coverage under a Primary Health Benefit Plan;
2. suicide or any attempt thereat, while sane or insane;
3. any intentionally self-inflicted Injury or Sickness, while sane or insane;
4. voluntary abortion except:
  - a. where the Insured's or the Dependent's life would be endangered if the fetus were carried to term; or
  - b. where medical complications have arisen from abortion;
5. any Injury or Sickness as a result of Participation in a Riot, civil commotion, civil disobedience or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority. For purposes of this exclusion, "Participation" means to take an active part in common with others; "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law;
6. a Covered Person engaging in any act or occupation which is a violation of the law of the jurisdiction where the loss or cause of loss occurred. A violation of law includes both misdemeanor and felony violations;
7. participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, scuba diving, stunt driving, rock climbing, flying ultra-light aircraft, skydiving, hang gliding or any hazardous sports activity for exhibition purposes;
8. Injury or Sickness as a result of air travel, except:
  - a. as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - b. as a passenger for transportation only and not as a pilot or crew member;
9. any Injury that occurs while a Covered Person has been determined to be intoxicated:
  - a. by judicial or administrative judgment or order;
  - b. by evidence of an alcohol concentration in the Covered Person's blood, breath or urine which equals or exceeds the limits set by applicable motor vehicle laws; or
  - c. by other evidence demonstrating the Covered Person was under the influence of any



- alcohol, narcotic, barbiturate or hallucinatory drug, unless the same was administered on the advice of a Physician and was taken according to the prescribed dosage; and the use of such substance was a proximate cause of the Injury;
10. alcoholism or drug use, unless administered on the advice of a Physician and was taken according to the prescribed dosage;
  11. procedures associated with a sex change, unless covered under the Primary Health Benefit Plan;
  12. any treatment, drugs or surgery considered experimental by the American Medical Association, the Health Care Finance Administration, or the Federal Drug Administration, unless covered under the Primary Health Benefit Plan;
  13. any loss while the Covered Person is in the service of the Armed Forces of any country. Orders to active military service for training purposes of two months or less will not constitute service in the Armed Forces. Upon notice to the Company of entering the Armed Forces, the Company will return to the Covered Person pro rata any Premium paid, less any benefits paid, for any period during which the Covered Person is in such service;
  14. Injury or Sickness for which compensation is payable under any Workers' Compensation Law, any Occupational Disease Law or similar legislation;
  15. mental illness or functional or organic nervous disorders, unless covered under the Primary Health Benefit Plan;
  16. dental or vision services, including, but not limited to, treatment, surgery, extractions or x-rays, unless:
    - a. resulting from an Injury occurring while the Covered Person's coverage under the Policy is in force and if performed within 12 months of the date of such Accident; or
    - b. due to congenital disease or anomaly of a Dependent newborn child;
  17. routine examinations, unless the Physician Office Visit Benefit is listed in the Schedule of Benefits, such as health exams, periodic check-ups, or routine physicals;
  18. any expense for which benefits are excluded under the Primary Health Benefit Plan.

## **GENERAL PROVISIONS**

### **Absence of Other Medical Plan:**

Coverage under the Policy will be terminated for such Covered Person, and any other person in the same family unit, whose coverage under the Primary Health Benefit Plan has been terminated. Such Covered Person(s) will not be entitled to any Extensions or Continuations described in Section 5, except COBRA Continuation, where applicable.

### **Assignment**

You may assign the Benefits of the Policy to the Provider rendering health care services. You may not assign the Policy in any other way or to any other person. We must be notified in Writing of the assignment. The assignment will not be effective until we receive the Written notice. We assume no responsibility for the validity of any assignment.

### **Changes to Policy**

The Policy may be amended at any time by written agreement between the Policyholder and Us, without the consent of or notice to any other individual. Any amendment to the Policy must be in Writing and be attached to it. The amendment must bear the signature or a reproduction of the signature of an officer of the Company.

If an employee who is otherwise eligible for insurance is not Actively at Work on the Effective Date of the amendment, the effective date with respect to that employee will be on the date that he or she is again Actively at Work. However, if the amendment reduces the amount of insurance to which the employee is entitled, the effective date will be the effective date of the amendment.

### **Incontestability - Time Limit on Certain Defenses**

We will not use misrepresentations made by You in a written application to contest the validity of the insurance with respect to which such statement was made, after such insurance has been in force prior to the contest for a period of two years during Your lifetime, unless the misrepresentations are fraudulent. This

section does not prevent Us from using at any time a defense based on:

1. non-payment of Premium; or
2. any other provision of the Policy; or
3. any other defense that is allowed by law.

If You apply to add additional Covered Persons, the incontestable period with respect to newly added Covered Persons is for two years from such Covered Person's effective date. If You apply for increased Benefits under the Policy, We will not use misrepresentations made by You in a written application for such increase to contest the validity of the increased insurance with respect to which such statement was made, after such increase has been in force prior to the contest for a period of two years from the effective date of the increase.

### **Errors**

You must be properly insured under the Policy. An error or omission by the Policyholder or by Us will not cause You to become Insured. An error or omission by the Policyholder or by Us will not cancel insurance that should continue nor continue insurance that should end. The requirements of the Policy must be properly met for any change in the amount of Your insurance to take effect. We have the right to full recovery of any overpayments made. Such reimbursement will be required regardless of whether the overpayment occurred due to an error by Us, or by You, Your representative, Your beneficiary, or the Policyholder.

### **Legal Actions**

No action shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of six years after the time written proof of loss is required to be furnished.

### **Misrepresentation**

Any statement You make in an application to become insured is a representation and not a warranty. No representation made by You in an application to become insured will be used to reduce or deny Your Claim or contest the validity of Your insurance unless:

1. Your insurance would not have been approved except for Your misrepresentation; and
2. Your misrepresentation is contained in a written instrument Signed by You; and
3. We give You or Your representative a copy of the written instrument that contains Your misrepresentation.

### **Misstatement of Age or Fact**

If a Covered Person's age or any other fact was misstated, We will use the correct facts to determine whether he or she is insured and if so, for what amount and duration. We will adjust Premium rates to the Covered Person's correct age. We may make this change back to the date Coverage became effective based on the misstated information.

### **Notice to Policyholder**

Written notice given by Us to an authorized representative of the Policyholder shall be deemed notice to all affected Covered Persons in the administration of the Policy, including termination of the Policy and termination of individual Coverage under the Policy.

### **Workers' Compensation Not Affected**

The Policy does not replace or change any requirement for coverage under workers' compensation insurance.