Group Hospital Indemnity Certificate of Insurance

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

This certificate applies to insureds in the state of TX.

POLICYHOLDER:	AHS Management Company, Inc. dba Ardent Health Services
POLICY NUMBER:	76388
POLICY EFFECTIVE DATE:	January 1, 2025
CERTIFICATE EFFECTIVE DATE:	This certificate represents the plan in effect as of January 1, 2025.
	This certificate replaces any and all certificates previously issued to you under the group policy. Please replace any certificate previously issued to you with this new certificate.
ASSOCIATED COMPANIES:	All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.
POLICY SITUS STATE:	The policy was issued and delivered in Tennessee.

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010. YOU SHOULD CONFIRM WITH YOUR TAX ADVISOR THAT THIS INSURANCE DOES NOT IMPACT ELIGIBILITY TO CONTRIBUTE TO AN HSA, IF APPLICABLE TO YOU.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare published by Medicare.gov and available from us.

The Company may change the required premiums as a condition of any renewal of the group policy.

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown in the Certificate Specification section. This certificate is not a contract nor does it modify or amend the group policy. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. The group policy is the contract between the policyholder and Securian Life. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

Renée D. Montz
Secretary

President

GROUP HOSPITAL INDEMNITY CERTIFICATE OF INSURANCE • NONPARTICIPATING

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company 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. If you don't, you may lose your right to appeal.

Securian Life Insurance Company
To get information or file a complaint with your insurance company:
Call: Consumer Complaints, toll free at: 1-855-651-3500
Email: ConsumerComplaints@securian.com
Mail: 400 Robert Street North, St. Paul, MN 55101-2098

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿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. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

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

Securian Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:
Llame a: Consumer Complaints, teléfono gratuito al 1-855-651-3500
Correo electrónico: ConsumerComplaints@securian.com
Dirección postal: 400 Robert Street North, St. Paul, MN 55101-2098

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

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ENTIRE CONTRACT

If you meet the eligibility and enrollment requirements as shown herein, you are insured under the group policy**.** Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application (if any) will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless a copy of the written instrument containing the statement has been provided to you, or in the event of your death or incapacity, to your beneficiary or personal representative.

This certificate is issued in consideration of (if any) and the payment of any required premium.

CERTIFICATE SPECIFICATIONS

Group:
The group is composed of all active employees of the policyholder working in the United States in the following class:

Class 1: All eligible active employees

All new employees of the employer will be added to such group and classes for which they become eligible.

Associated companies' eligibility:
Employees of associated companies may be eligible for insurance under the group policy. The policyholder must report any associated companies to us for inclusion under the group policy, subject to the employee and associated company meeting all eligibility requirements. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

Minimum hour per week requirement:
The number of hours your employer requires you to be actively at work in order to be eligible for coverage under this certificate. Your minimum hour per week requirement is 20 hours per week.

Employment waiting period:
The period of continuous employment with the employer that you must satisfy prior to becoming eligible for coverage under this certificate. Your employment waiting period is the period commencing with your date of employment and ending with the first day of the month next following or coinciding with your completion of 30 days of continuous employment. You are not eligible to become insured until the first day following the waiting period.

Eligibility:
You are eligible for group hospital indemnity insurance if you meet all the following requirements:

(1) are a member of the eligible group and of an eligible class;
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement;
(3) have satisfied the waiting period, if any; and
(4) meet the actively at work requirement.

Dependent eligibility:
If you are insured for group hospital indemnity insurance coverage, your dependents are eligible for insurance.

Enrollment period:
You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 31 days of when you first become eligible. After that period you can only enroll for coverage or make changes during your annual open enrollment or within 31 days of a qualified status change event as defined by the policyholder's plan rules.

You will become insured on the date you meet all eligibility requirements.

Effective date of coverage:
Your insurance becomes effective on the date all of the following conditions have been met:

(1) you meet all eligibility requirements, including the actively at work requirement; and
(2) for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us.

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

(1) your insurance becomes effective;
(2) the dependent meets all eligibility requirements; and
(3) for contributory insurance, you apply for dependent coverage on forms which are approved by us.

Double coverage:
If you are eligible as an employee under the policy, or insured under the portability provisions, you are not eligible as a dependent. Only you can insure an eligible dependent child.

Actively at work requirement:
To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-workday, coverage will not be delayed provided you were actively at work on the workday immediately preceding the non-workday.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

Dependent non-confinement requirement:
If a dependent is hospitalized or confined because of an illness or injury on the date their insurance would otherwise become effective, their effective date shall be delayed until they are released from such hospitalization or confinement. This does not apply to a newborn child. In no event will insurance on a dependent be effective before your insurance is effective.

Continuation during a leave of absence:
Insurance may be continued when you are not actively at work due to illness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment and is subject to the following maximum time frames:

(1) if you are on a non-medical leave of absence or temporary layoff, insurance cannot be continued beyond 12 months from the last day you were actively at work.
(2) if you are on a medical leave of absence, insurance cannot be continued beyond the later of 12 months from the last day you were actively at work or attained age 65.

Continuation of insurance must be in accordance with practices and procedures that preclude individual selection.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements. The above limits will be expanded, if necessary, in order to meet such requirements.

Changes in your coverage amount:
Requested increases in the amount of your contributory insurance are effective on the date as shown below in the Annual open enrollment and Qualified status changes sections. Requested decreases in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a decrease. In addition, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

Change of insurance carriers
If you are not actively at work due to illness or injury on the date the policyholder changes its insurance carrier to us, and you were covered under the policyholder's prior policy at the time coverage under us became effective, we will provide coverage under our insurance policy.

Coverage provided under our insurance policy is subject to payment of premiums.

Guaranteed issue:
Guaranteed issue is the maximum amount of insurance you, your spouse, or child can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period.

For an employee:
- Supplemental insurance: All supplemental insurance is guaranteed issue.

For a spouse:
- Supplemental insurance: All supplemental insurance is guaranteed issue.

For a child:
- Supplemental insurance: All supplemental insurance is guaranteed issue.

For an eligible employee and eligible dependent who was covered for Hospital Indemnity under the employer's plan immediately prior to the policy effective date shown above, the guaranteed issue for Hospital Indemnity is the amount of insurance in force under that prior plan immediately prior to the policy effective date.

Annual open enrollment:
During the policyholder's annual open enrollment you may elect or change your and your dependent's hospital indemnity insurance benefit plan. All coverage is guaranteed issue. Coverage will be effective on the January 1 following the annual open enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement requirement for dependents.

Qualified status changes:
If you experience one of the qualified status change events listed below you elect or change your and your dependent's hospital indemnity insurance benefit plan provided enrollment is made within 31 days of the status change. All coverage is guaranteed issue.

Qualified status change for purposes of the enrollment opportunities described above means marriage or establishment of a legal partnership, birth of a child, filing of a petition to adopt a child, entering into a suit in which you are seeking to adopt a child, adoption of a child, placement of a foster child or acquisition of a stepchild.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement and the hospitalization/non-confinement requirement for dependents.

PLAN OF INSURANCE

Employee Benefit Schedule

Employee Supplemental Hospital Indemnity Insurance

Eligible Class	**Supplemental Hospital Indemnity Insurance Benefit Plan**
Class 1	Low Plan or High Plan as elected by you.
Contributory/Non-Contributory:	Supplemental hospital indemnity insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Spouse Benefit Schedule

You must be insured for supplemental hospital indemnity insurance in order to elect spouse hospital indemnity insurance.

Spouse Supplemental Hospital Indemnity Insurance

Eligible Class	Supplemental Hospital Indemnity Insurance Benefit Plan
Class 1	Spouse supplemental benefit plan will match your supplemental hospital indemnity benefit plan.

Contributory/Non-Contributory: Supplemental hospital indemnity insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Child Benefit Schedule

You must be insured for supplemental hospital indemnity insurance in order to elect child hospital indemnity insurance.

Child Supplemental Hospital Indemnity Insurance

Eligible Class	Supplemental Hospital Indemnity Insurance Benefit Plan
Class 1	Child supplemental benefit plan will match your supplemental hospital indemnity benefit plan.

Contributory/Non-Contributory: Supplemental hospital indemnity insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Automatic Child Coverage: If you currently have dependent child coverage and you have a newborn child, grandchild, adopted child, or stepchild, then your newborn child, grandchild, adopted child or stepchild will be automatically covered for the amount of child coverage outlined in the Plan of Insurance section from date of live birth, adoption, or the date you acquire a stepchild.

If you currently have dependent child coverage and you have a foster child, child of legal ward, a child of court-appointed guardianship, or a child of court-ordered custody or administrative order placed with you, the child will be automatically covered for the amount of child coverage outlined in the Plan of Insurance section from date the child becomes eligible according to the definition of child outlined within the Definition Section of this certificate.

If you currently do not have dependent child coverage and you have a newborn child, grandchild, adopted child, or stepchild, your newborn child, grandchild, adopted child or stepchild will automatically be covered for the amount of child coverage outlined in the Plan of Insurance section for the first 61 days following the date of live birth, the date of adoption, or the date you acquire a stepchild. The coverage will terminate at the end of the 61 day period unless you apply for dependent child coverage within the 61 days of the live birth, the date of adoption, or the date you acquire a stepchild and pay the additional premium for coverage.

If you currently do not have dependent child coverage and you have a foster child, child of legal ward, a child of court-appointed guardianship, or a child of court-ordered custody or administrative order placed with you, the child will automatically be covered for the amount of child coverage outlined in the Plan of Insurance section for the first 61 days as of the date the child is eligible according to the definition of child outlined within the Definition Section of this certificate. The coverage will terminate at the end of the 61 day period unless you apply for dependent coverage within 61 days of the child becoming eligible according to the definition of child outlined within the Definition Section of this certificate.

NOTE: If you had previously declined to enroll in dependent child coverage for your eligible children, you may still elect child coverage for any newly eligible child according to the enrollment period rules shown within the Certificate Specifications section of this certificate.

PLAN OF INSURANCE – ADDITIONAL BENEFITS

Employee Additional Benefit Schedule

Employee Supplemental Designated Facility Benefit

Eligible Class	Supplemental Designated Facility Benefit
Class 1	See the Covered Hospital Benefits table under the Designated Facility Benefit described under the Additional Benefits section.

Employee Supplemental Wellness Screening Benefit

Eligible Class	Supplemental Wellness Screening Benefit
Class 1	$50

Employee Portability Benefit

Eligible Class	Portability Benefit
Class 1	**Minimum Amount:** The lowest level of coverage. **Maximum Amount:** You may elect from any of the offered level(s) of coverage under the supplemental insurance in the Plan of Insurance section that does not exceed the level of coverage in force on your portability date.

Spouse Additional Benefit Schedule

Spouse Supplemental Designated Facility Benefit

Eligible Class	Supplemental Designated Facility Benefit
Class 1	See the Covered Hospital Benefits table under the Designated Facility Benefit described under the Additional Benefits section.

Spouse Supplemental Wellness Screening Benefit

Eligible Class	Supplemental Wellness Screening Benefit
Class 1	$50

Spouse Portability Benefit

Eligible Class	Portability Benefit
Class 1	**Minimum Amount:** The lowest level of coverage. **Maximum Amount:** A level of coverage which does not exceed the spouse's supplemental level of coverage in force on their portability date.

Child Additional Benefit Schedule

Child Supplemental Designated Facility Benefit

Eligible Class	Supplemental Designated Facility Benefit
Class 1	See the Covered Hospital Benefits table under the Designated Facility Benefit described under the Additional Benefits section.

Child Supplemental Wellness Screening Benefit

Eligible Class	Supplemental Wellness Screening Benefit
Class 1	$50

Child Portability Benefit

Eligible Class	Portability Benefit
Class 1	**Minimum Amount:** The lowest level of coverage. **Maximum Amount:** A level of coverage which does not exceed the child's supplemental level of coverage in force on their portability date.

COVERED HOSPITAL BENEFITS

Your plan includes a Designated Facility Benefit. Please refer to the Additional Benefits Designated Facility Benefit section for benefit amounts if services are received at a designated facility.

BENEFITS	LOW PLAN	HIGH PLAN
Hospital stay		
Daily hospital stay benefit (1-30 days)	$100	$200
Initial hospital stay benefit	$500	$1,000
Intensive care unit (ICU) hospital stay benefit (1-30 days)	$100	$200
Initial intensive care unit (ICU) hospital stay benefit	$1,000	$2,000
Inpatient mental health disorder stay	$100	$200
Inpatient substance use disorder stay	$100	$200
Newborn routine stay	$250	$500
Outpatient mental health and substance use disorder diagnostic screening	$100	$200

DEFINITIONS

Any term used in this certificate is given the meaning as defined in this section unless otherwise defined in another provision of this certificate.

accident
An act or event which is:

(1) unintended, unexpected, and unforeseen; and
(2) directly results in bodily injury to the insured.

application
Your application or enrollment for insurance under the group policy.

associated company
Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and reported to and agreed to by us to participate under the group policy.

child or children
Your or your spouse's:

(1) natural child;
(2) adopted child;
(3) stepchild;
(4) foster child;
(5) grandchild;
(6) legal ward;
(7) a child in your or your spouse's court-appointed guardianship;
(8) a child in your or your spouse's court-ordered custody; or administrative order; or
(9) a child for whom you have been ordered to provide medical support.

Children are eligible from the moment of live birth (stillborn or unborn children are not eligible) to the attainment of age 26. Children age 26 or older are eligible as a dependent child provided the child is physically or mentally incapable of self-support, was incapable of self-support prior to age 26 and remains physically dependent on you for their support and maintenance. Coverage on a qualified dependent child age 26 or older that continues beyond limiting age shall remain at the child premium rate. If you are a newly eligible employee, you may insure your child who is over the age of 26 provided the child is physically or mentally incapable of self-support, was incapable of self-support prior to age 26 and remains financially dependent on you for their support and maintenance.

Adopted child includes children for whom you or your spouse have filed a petition to adopt, or for whom you or your spouse are a party to a suit in which you are seeking to adopt the child. Children for whom you or your spouse have filed a petition to adopt within 60 days of the adopted child's date of birth, are eligible from the moment of live birth (stillborn or unborn children are not eligible). Coverage for an adopted child is effective from the earliest of adoption, placement for adoption, the date of a suit seeking adoption, or filing of the petition for adoption.

Foster child includes a child from the moment of placement in the foster home.

Grandchild means a grandchild:

(1) who is unmarried;
(2) younger than 25 years of age; and
(3) is dependent on you for federal income tax purposes at the time application for coverage of the grandchild is made.

complications of pregnancy
Conditions or diseases whose diagnoses are distinct from routine pregnancy but are adversely affected or caused by pregnancy.

Such conditions include:
- acute nephritis
- cardiac decompensation
- eclampsia
- missed abortion
- nephrosis
- non-elective cesarean section
- puerperal infection
- spontaneous end of a pregnancy that occurs during a period of gestation in which a viable birth is not possible
- termination of ectopic pregnancy
- other conditions of comparable severity

Complication of pregnancy does not include:
- elective cesarean section
- false labor
- hyperemesis gravidarum

- morning sickness
- multiple gestation pregnancy
- occasional spotting
- physician prescribed rest during a pregnancy
- pre-eclampsia
- other conditions associated with pregnancy that are not diagnosed as a complication of pregnancy as defined above

confined or confinement
The assignment to a bed as a resident inpatient in a hospital (including an intensive care unit of a hospital) or confinement in an observation area within a hospital for a period of no less than 18 continuous hours.

contributory insurance
Insurance for which you are required to make premium contributions.

covered accident
An accident which:

(1) is not excluded under the Exclusions section or any other terms of this certificate;
(2) occurs while the insured's coverage is in force under this certificate;
(3) occurs in the United States or a United States territory; and
(4) occurs during and outside the course and scope of your employment.

dependent
Your spouse or child(ren).

If your spouse is eligible as an employee under the group policy, they are not eligible to be insured as a dependent spouse. If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, they are not eligible to be insured as a dependent child.

emergency care
Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient"s health in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

emergency room
A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised by physicians, have treatment provided by physicians, and available for care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

(1) diagnostic care, including laboratory services and diagnostic x-rays; and
(2) treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

An emergency room or a satellite emergency center does not include a hospital, an urgent care facility, or an office maintained by a licensed physician for the practice of medicine or dentistry.

employee
An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer
The policyholder or any designated associated companies.

evidence of insurability
Evidence satisfactory to us of the insurability of the prospective insured and any other underwriting information we require.

family member
A parent, spouse, child, sibling, grandparent, grandchild, aunt, uncle, first cousin, niece, or nephew. This includes adopted, in-law, and step relatives.

guaranteed issue amount
Insurance that can be obtained without providing evidence of insurability based on plan requirements as shown in the Certificate Specification section of this certificate. All other eligibility requirements must be met. All insurance under this certificate is guaranteed issue.

hospital
A short-term, acute care general facility that:

(1) is legally licensed and operated as a hospital;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by a physician;
(4) provides 24-hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.

A hospital is not a rehabilitation facility, nursing home, rest home, extended-care facility, convalescent home, hospice care facility, skilled nursing facility, assisted living facility, a substance use facility, or a mental health facility, even if such facilities are affiliated with or adjoined to a hospital.

illness
A disease, sickness, or condition which is diagnosed or treated by a physician. Illness includes complications of pregnancy, routine pregnancy, and routine delivery unless excluded under the Exclusions and Limitation section.

injury or injuries
A bodily injury which is sustained as a direct result of a covered accident.

inpatient
Medical advice, care, diagnostic measures, or treatment provided while admitted as a resident inpatient to a hospital.

insured
An employee or dependent covered for insurance under this certificate.

intensive care unit (ICU)
Refers to a specifically designated part of a hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. Hospital Intensive Care Units must be:

(1) separate and apart from the surgical recovery room;
(2) separate and apart from rooms, beds, and wards customarily used for patient confinement;
(3) permanently equipped with special life-saving equipment to care for the critically ill or injured; and
(4) under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit.

legal partner
The person with whom you have entered into a legally sanctioned domestic partnership or civil union partnership that grants the partners the same rights, responsibilities, and obligations as married couples in accordance with applicable law. Legal partner does not include any person who is eligible as an employee.

mental health disorder
Any condition, disease or disorder listed as a mental health disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other related mental health diagnoses, where improvement can be reasonably expected with therapy.

non-workday
A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends, holidays, or approved leaves of absence for non-medical reasons.

Non-workday does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, or any time off due to illness or injury including sick days, short-term disability, or long-term disability.

outpatient
Medical advice, care, diagnostic measures, or treatment provided without being admitted as a resident inpatient to a hospital.

physician
A person who is licensed to practice medicine in the United States or United States territory in which treatment is received and who is providing treatment or advice in accordance with the license. Relevant law may require or allow for consideration of professional services of a practitioner other than a medical doctor. If so, such practitioner must be licensed as required by the jurisdiction where care is given and must be operating in the scope of their license. Other than for a dentist providing emergency dental care, we will not recognize you, your family member, a person who ordinarily resides in your household, or a business or professional partner, or any person who has a financial affiliation or business interest with you as a physician for a claim submitted to us.

policyholder
The owner of the group policy.

routine delivery
Routine vaginal delivery of a child or children or delivery of a child or children by non-emergency cesarean section.

routine pregnancy
A pregnancy that does not include complications of pregnancy.

skilled nursing facility
An institution that meets all of the following standards:

(1) it is licensed by the state in which it is located;
(2) it is a separate facility, or a distinct part of another facility physically separated from the rest of such facility;
(3) it provides inpatient nursing care to individuals who are not able to care for themselves and who require nursing care;
(4) the care must be performed under the direction of a licensed physician or licensed nurse; and
(5) it is not a hospital, a home for the aged, a retirement home, a rest home, a community living center, or a place mainly for the treatment of substance use or mental health disorders.

spouse
Your legally married spouse. For the purposes of this certificate, spouse shall also include legal partner. Spouse does not include any person who is eligible as an employee.

substance use disorder
The pattern of pathological use of alcohol, psychoactive drugs, or substances characterized by:

(1) impairments in social and/or occupational functioning;
(2) debilitating physical condition;
(3) inability to abstain from or reduce consumption of the substance; or
(4) the need for daily substance use to maintain adequate functioning.

surgery
Medical treatment in which a physician cuts into someone’s body in order to repair or remove damaged or diseased parts.

telemedicine
The use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the evaluation, diagnosis, or treatment of the insured as would be practiced in person. This does not include requests for prescription refills or medical records.

urgent care facility
A health care facility:

(1) that maintains all appropriate licensing for a facility that provides urgent or immediate care;
(2) that is supervised by a physician;
(3) that is separate from a hospital or is a separate unit within a hospital; and
(4) the primary purpose of which is the offering and provision of immediate, short-term medical care.

An urgent care facility does not include an emergency room or a satellite emergency center.

we, our, us
Securian Life Insurance Company.

year
The benefit year beginning on any month within the calendar year or plan year. The calendar year and/or plan year is determined by the policyholder. In no event will a calendar year and/or plan year be more than 12 months.

you, your, certificate holder
An insured employee.

COVERED HOSPITAL BENEFITS

Hospital stay

If an insured suffers an illness or injury and requires confinement in a hospital for the illness or injury, we will pay the appropriate hospital stay benefit shown in the Covered Hospital Benefits section.

If an insured is discharged and is subsequently confined within 90 days of the discharge date because of the same or related condition, it will be considered a continuation of the same confinement.

A hospital stay benefit is payable only if an insured's confinement begins while the insured's coverage is in force. A hospital stay benefit will not be payable if an insured's confinement is due solely to a substance use disorder on an inpatient basis or if an insured's confinement is due solely to mental health disorder treatment on an inpatient basis.

The hospital stay benefit is limited to 1 separate confinement per insured per year and is subject to the following.

Daily hospital stay benefit
We will pay the daily hospital stay benefit shown in the Covered Hospital Indemnity Insurance Benefits for each day the insured is confined in the hospital, including the first day. The daily hospital stay benefit will be limited to a maximum of 30 days per insured per confinement.

Initial hospital stay benefit
We will pay the initial hospital stay benefit shown in the Covered Hospital Indemnity Insurance Benefits for the insured's first day he or she is confined in the hospital. This benefit is paid in addition to the daily hospital stay benefit for the first day of the confinement.

Intensive care unit (ICU) hospital stay benefit
If the insured requires confinement in an intensive care unit (ICU) of a hospital, we will pay the intensive care unit hospital stay benefit shown in the Covered Hospital Indemnity Insurance Benefits. The ICU hospital stay benefit will be limited to one benefit per day per insured up to a maximum of 30 days per insured per confinement. This benefit is paid in lieu of the daily hospital stay benefit.

Initial intensive care unit (ICU) hospital stay benefit
If an insured requires confinement in an intensive care unit (ICU) of a hospital, we will pay the initial ICU hospital stay benefit shown in the Covered Hospital Indemnity Insurance Benefits for the insured's first day he or she is confined in an ICU. This benefit is paid in addition to the intensive care unit hospital stay benefit for the first day of the confinement in an ICU. This benefit is paid in lieu of the initial hospital stay benefit.

Inpatient mental health disorder stay

An inpatient mental health stay benefit as shown in the Covered Hospital Benefits section is payable for each day an insured is receiving treatment for a mental health disorder(s) on an inpatient basis in a hospital, mental health facility, or residential treatment facility for mental health.

This benefit does not include inpatient mental health treatment received in a nursing home, rest home, extended-care facility, convalescent home, skilled nursing facility, hospice care facility, or assisted living facility.

In the event an insured is eligible for both an inpatient substance use disorder stay benefit and an inpatient mental health disorder stay benefit on the same day, only one benefit will be paid. If the benefit amounts are the same, the insured can choose the benefit to be paid. If the benefit amounts differ, the higher benefit will be paid.

The inpatient mental health disorder stay benefit is payable only if the insured's inpatient treatment begins while the insured's coverage is in force. This benefit is limited to one benefit per insured per day and 30 benefits per insured per year.

If an insured is discharged and subsequently receives mental health disorder treatment on an inpatient basis within 90 days of the discharge date, it will be considered a continuation of the same treatment.

Inpatient substance use disorder stay

An inpatient substance use disorder stay benefit as shown in the Covered Hospital Benefits section is payable for each day an insured is receiving treatment on an inpatient basis in a hospital or residential treatment facility for a substance use disorder.

This benefit does not include the use of nicotine and caffeine.

This benefit does not include inpatient substance use disorder stay received in a nursing home, rest home, extended-care facility, convalescent home, hospice care facility, skilled nursing facility, or assisted living facility.

In the event an insured is eligible for both an inpatient substance use disorder stay benefit and an inpatient mental health disorder stay benefit on the same day, only one benefit will be paid. If the benefit amounts are the same, the insured can choose the benefit to be paid. If the benefit amounts differ, the higher benefit will be paid.

The inpatient substance use disorder stay benefit is payable only if an insured's inpatient treatment begins while the insured's coverage is in force. This benefit is limited to one benefit per insured per day and 30 benefits per insured per year.

If an insured is discharged and subsequently receives inpatient substance use disorder treatment on an inpatient basis within 90 days of the discharge date, it will be considered a continuation of the same treatment.

Newborn routine stay

A newborn routine stay benefit as shown in the Covered Hospital Benefits section may be payable for each day your or your insured spouse's newborn child is confined following delivery, including the day of delivery and is not confined due to illness or injury.

This benefit is limited to one benefit per newborn child per day up to a maximum of 1 continuous day.

If the newborn child's confinement is due to illness or injury, the hospital stay benefit would be payable.

Outpatient mental health and substance use disorder diagnostic screening

If an insured receives an outpatient mental health or substance use disorder diagnostic screening listed below, we will pay the outpatient mental health and substance use disorder diagnostic screening benefit shown in the Covered Hospital Benefits section. For purposes of this benefit, care received through telemedicine meets the benefit description of an outpatient mental health and substance use disorder diagnostic screening.

Diagnostic screenings must be administered by a physician.

The following screenings or their equivalent are included:

(1) Depression Screening
- Patient Health Questionnaire (PHQ-9)

(2) Substance Use Disorder Screening
- Alcohol Use Disorders Identification Test (AUDIT)
- Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS)
- Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD)
- Screening to Brief Intervention (S2BI)

- CAGE AID
- Drug Abuse Screen Test (DAST-10)

(3) Bipolar Disorder Screening
- Mood Disorder Questionnaire (MDQ)

(4) Suicide Risk Screening
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

(5) Anxiety Disorders Screening
- Generalized Anxiety Disorder (GAD-7)
- Primary Care PTSD Screen (PC-PTSD)

(6) Attention Deficit Hyperactive Disorder (ADHD) - This benefit only applies to insured children.
- DIVA 2.0
- Conners' Adult ADHD rating scale (CAARS)
- Adult ADHD Self Report Scale (ARS)
- Behavioral Assessment System for Children (BASC)
- Vanderbilt Assessment Scale
- The Conners' Rating Scale
- Child Attention Profile (CAP)

(7) Autism - This benefit only applies to insured children.
- Diagnostic Interview-Revised (ADI-R)
- Diagnostic Observation Schedule-2nd (ADOS-2)
- Childhood Autism Rating Scale 2nd Addition (CARS-2)

(8) Schizophrenia
- Schizophrenia must be evaluated by a psychiatrist

(9) Trauma Screening
- Life Event Checklist (LEC)
- PTSD Checklist – Civilian Version (PCL-C)

This benefit is limited to one benefit per insured per visit, one benefit per insured per day and 1 benefit per insured per year.

EXCLUSIONS

In no event will we pay benefits where the insured's injury or illness is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

(1) intentionally self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane (this exclusion does not apply to the inpatient substance use disorder stay benefit or the inpatient mental health disorder stay benefit);
(2) suicide or attempted suicide, whether sane or insane (this exclusion does not apply to the inpatient substance use disorder stay benefit or the inpatient mental health disorder stay benefit);
(3) the insured's participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto;
(4) the insured's use of alcohol (this exclusion does not apply to the inpatient substance use disorder stay benefit or the inpatient mental health disorder stay benefit);
(5) the insured's use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected unless taken or used as prescribed by a physician, or an over-the-counter drug as directed by the manufacturer (this exclusion does not apply to the inpatient substance use disorder stay benefit or the inpatient mental health disorder stay benefit);
(6) war or any act of war, whether declared or undeclared;
(7) dental or plastic surgery for cosmetic purposes except when due to: a) reconstructive surgery, when the service is related to or follows surgery resulting from an injury or illness; or b) a congenital disease or anomaly of a covered dependent child; or c) congenital defects in newborns; or
(8) a newborn child's routine nursing or routine well baby care during the initial confinement in a hospital (this exclusion does not apply to the newborn routine stay benefit).

In no event will we pay benefits where the insured's accident or injury is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

(1) motor vehicle collision or accident where the insured is the operator of the motor vehicle and the insured's blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto;
(2) bodily or mental infirmity, illness;
(3) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury;
(4) the insured traveling in or descending from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft;
(5) the insured participating in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing;
(6) the insured riding or driving in any motor-driven vehicle in a race, stunt show or speed test;
(7) resulting complications from medical or surgical treatment or diagnostic procedures when the outcome is not as planned or expected, including claims of medical malpractice; or
(8) the insured practicing for or participating in any semi-professional or professional competitive athletics.

Benefits are not payable for any confinement, care, treatment, or diagnostic measures which were received outside of the United States or a United States territory.

CERTIFICATE TERMINATION

Your coverage ends on the earliest of the following:

(1) the date you no longer meet the eligibility requirements;
(2) 31 days (the grace period) after the due date of any premium which is not paid;
(3) the last day for which premium contributions have been paid following your request to cancel your coverage; or
(4) the date the group policy ends.

Your insured dependent's coverage ends on the earliest of the following:

(1) the date the dependent no longer meets the eligibility requirements;
(2) 31 days (the grace period) after the due date of any premium contribution which is not paid;
(3) the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
(4) the date you are no longer covered under the group policy, unless the dependent's coverage is continued according to the terms of the Portability Benefit.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

Extension of Benefits
If an insured is totally disabled or confined in a hospital on the date the group policy terminates, an extension of benefits will be provided until the earliest of:

(1) 90 days after the date the group policy ends;
(2) the date the insured ceases to be totally disabled
(3) and the date the insured is no longer confined in a hospital.

This Extension of Benefits terminates upon the earliest of the following:

(1) the date you recover so that you are no longer totally disabled;
(2) the date you receive the maximum benefit for the injury; or
(3) 90 days after the date coverage would otherwise terminate.

ADDITIONAL BENEFITS

If you are insured under the provisions applicable to hospital indemnity insurance coverage under this certificate you are eligible for insurance under the following Additional Benefits below. In addition, your spouse or your dependent children are eligible if they are insured under this certificate. Insurance under these Additional Benefits become effective on the date you, your spouse, or your dependent child becomes insured under this certificate as outlined in the Certificate Specification section. Coverage under these Additional Benefits are subject to all terms, conditions, exclusions, limitations, and provisions of this certificate unless otherwise expressly provided for herein.

Designated Facility Benefit

This additional benefit will increase the amount payable for a covered hospital benefits when the insured utilizes an eligible client designated facility specified by the policyholder. We will pay the benefit upon receipt at our home office of written proof satisfactory to us as to both substance and form. Listed below are the increased amounts for a covered benefit. Benefits will be paid according to the Claims section of the certificate.

Eligible Facilities
Client designated facilities as reported to us by the policyholder.

Eligibility
the insured is eligible to receive a Designated Facility Benefit if the following conditions are fully met:

(1) the same benefit is payable according to the provisions of the Certificate to which this benefit is attached;
(2) the benefit is listed as a covered hospital benefit; and
(3) the insured utilized an eligible client designated facility.

Benefits
Benefits are limited to the covered hospital benefits expressly listed below and replaces the covered hospital benefit amounts listed earlier under the Covered Hospital Benefits section.

BENEFITS	LOW PLAN	HIGH PLAN
Hospital stay		
Daily hospital stay benefit (1-30 days)	$125	$250
Initial hospital stay benefit	$625	$1,250
Intensive care unit (ICU) hospital stay benefit (1-30 days)	$125	$250
Initial intensive care unit (ICU) hospital stay benefit	$1,250	$2,500
Inpatient mental health disorder stay	$125	$250
Inpatient substance use disorder stay	$125	$250
Newborn routine stay	$313	$625
Outpatient mental health and substance use disorder diagnostic screening	$125	$250

Termination
Insurance under this benefit will terminate on the earliest of the following:

(1) the date requested by the policyholder to cancel the designated facility coverage for its plan; or
(2) the terminating events outlined in the Certificate Termination section.

Wellness Screening Benefit

This benefit provides for an additional benefit to be paid to you if you, your covered spouse or your covered child undergo one of the wellness screenings listed below while not in a hospital on an inpatient basis. The payable amount of the Wellness Screening Benefit is shown in the Plan of Insurance – Additional Benefits section of the certificate. We will pay the benefit after receipt at our home office of proof satisfactory to us that you, your covered spouse or your covered child have undergone one of the covered screenings or preventive cares listed in this benefit. The benefit will be paid in a single sum. Benefits will be paid according to the Claims section of the certificate.

Wellness screenings or Preventive care

- annual physical exam;
- mental health screening recommended and performed by a physician;
- biopsies for cancer;
- blood chemistry panel;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- BRCA1/BRCA2 genetic testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- CA 15-3 breast cancer test;
- CA 125 ovarian cancer test;
- carotid Doppler;
- CEA colon cancer test;
- chest x-ray;
- clinical testicular exam;
- colonoscopy;
- dental exam;
- digital rectal exam (DRE);
- DNA stool analysis;
- doppler screening for cancer;
- doppler screening for peripheral vascular disease;
- double-contrast barium enema;
- echocardiogram;
- electrocardiogram (EKG);
- electroencephalogram (EEG);
- endoscopy;
- eye exam;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hearing exam;
- hemoccult stool specimen;
- hemoglobin A1C;
- herpes simplex virus (HSV) test;
- human papillomavirus (HPV) test;
- lipid panel;
- lung cancer CT;
- mammogram;
- non-diagnostic vascular screening;
- nucleic acid test (NAT);
- oral cancer screening;
- pandemic testing (excluding at home testing);
- pap smears or thin prep pap test;
- pharmacologic stress testing;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STI's);
- thermography;
- two-hour post-load plasma glucose test;
- ultrasounds;
- urinalysis;
- vaccinations approved by the FDA; or
- virtual colonoscopy.

Employer sponsored wellness screening or preventive care benefits conducted at the employer's place of business are not eligible for payment.

Benefit limitations
You, your spouse and each child can receive one supplemental Wellness Screening Benefit per year.

Termination
Insurance under this benefit will terminate on the earliest of the following:

(1) the date requested by the policyholder to cancel the wellness screening coverage for its plan; or
(2) the terminating events outlined in the Certificate Termination section.

Portability Benefit

This benefit provides for continuation of insurance if an insured no longer meets the eligibility requirements of certificate, except as provided for herein.

To continue insurance under this benefit, an insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Evidence of insurability will not be required. Coverage will remain in effect during the 31 day election period but not beyond this unless all continuation requirements are met. Upon satisfactory completion of all portability election requirements, coverage provided by this benefit will then be deemed effective retroactive to the beginning of the 31 day period. This date is considered to be the insured's portability date and the insured then is considered to have portability status.

If you elect to continue your own coverage according to the provisions of this benefit, you may elect to continue insurance for any other individual insured under your certificate. If your former spouse continues their own coverage they may elect to continue insurance on any insured children, provided you are not otherwise insuring the children. Benefits will be paid according to the Claims section of the certificate.

Eligibility
You are eligible to continue group hospital indemnity insurance under the terms of this benefit if you no longer meet the eligibility requirements due to any of the following:

(1) your termination of employment, including retirement;
(2) your number of working hours are reduced;
(3) you are no longer in a class eligible for insurance or on a leave or layoff; or
(4) a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy.

Your dependents are eligible to continue group hospital indemnity insurance under this benefit if they no longer meet the eligibility requirements due to any of the following:

(1) your termination of employment, including retirement;
(2) your number of working hours are reduced;
(3) you are no longer in a class eligible for insurance or on a leave or layoff;
(4) a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy;
(5) divorce;
(6) the dependent ceases to be an eligible dependent; or
(7) your death.

Regardless of whether an insured is otherwise eligible under this benefit to continue, an insured will not be eligible to request coverage under this benefit if they:

(1) have attained age 120;
(2) are an employee and were not actively at work due to illness or injury on the date immediately preceding the portability date;
(3) lose eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees;
(4) lose eligibility due to termination of the group policy; or
(5) do not reside in the United States or United States Territory.

If an insured is continuing coverage under the terms of this benefit, and again meets the eligibility requirements of the plan the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this benefit, unless and until the insured no longer meets the eligibility requirements of the plan and again returns to portability status as provided for herein.

Benefit amounts
The benefit amounts that can be continued under this additional benefit shall be the amounts shown on the Plan of Insurance section applicable to the insured based on the benefit plan selected by you.

An insured employee and a dependent who ports coverage on their own as provided under the terms of this Additional Benefit may change the benefit plan to one that provides a lower benefit amount but may not change the benefit plan to one that provides a higher benefit amount.

Additional Benefits
All Additional Benefits will terminate upon porting except the Wellness Screening Benefit.

Premiums
Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

The premium rates for ported coverage may be different than the premium rates for active employees and are not subject to the premium rate provision of the policy.

Termination
No individual may elect coverage under this benefit on or after the date of termination of the group policy.

An insured's Insurance continued under this benefit will remain in force until terminated on the earliest of the following:

(1) the insured's 120th birthday;
(2) the date the insured again meets the eligibility requirements of the certificate, not including the terms of this benefit;
(3) in the case of a dependent spouse or child the date your coverage is no longer being continued under this benefit or the date the spouse or child ceases to be eligible as defined under the terms of your plan, unless the spouse or child has ported coverage on their own as provided for under the terms of this benefit;
(4) the date the group policy is terminated;
(5) 31 days after the due date of any premium contribution which is not made;
(6) 31 days after we give written notice of our intent to terminate ported coverage for a group or class of individuals; or
(7) the date the insured requests to terminate their coverage being continued under this benefit.

Premiums

Premium due date
Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis.

Premium determination
The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Grace period
The group policy has a 31 day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31 day period following the due date. The insurance under the group policy will remain in effect during the 31 day grace period.

Reinstatement
If coverage terminates due to non-payment of premium, it may be reinstated.

Reinstatement must occur while the insured is living and within 60 days from the date of coverage termination. To reinstate, all back due premiums must be paid. After all back due premiums are paid, your coverage will be reinstated as if there were no lapse in coverage. Any loss that occurred during the lapse period will be covered.

Claims

We are providing notice that Securian Life Insurance Company is subject to economic and trade sanctions, laws, and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control (OFAC), prevent Securian Life Insurance Company from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

Notice of claim
Written notice of claim must be given to us within 365 days of the date of a loss. Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time and notice was given as soon as was reasonably possible. Notice given by or on the insured's behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

We will acknowledge receipt of the claim, commence any investigation of the claim and request all items, statements and forms that we reasonably believe, at that time, will be required from you, not later than the 15th day after the date we receive notice of claim.

Claim forms
Upon receipt of notice of claim, we will provide a claim form to you. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character, and extent of the loss for which claim is made which is satisfactory to us.

Proof of loss
Written proof of a loss satisfactory to us must be provided to us within 180 days of the date of the loss or as soon as reasonably possible. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 180 day period. However, proof must be provided within 15 months of the date proof of loss is required, except in the absence of legal capacity.

Physical examination and autopsy
After an insured has filed a claim and provided at their expense all requested claim forms and records, we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

We, at our own expense, may reasonably require during the pendency of a claim an autopsy in case of death, where it is not forbidden by law.

Payment of claims
We will pay a benefit for a loss within 60 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. All benefits including dependent's benefits will be paid to you, if you are living, or to your assignee. This benefit will be paid in a single sum or by any other method agreeable to us and the beneficiary. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

We may pay benefits for a dependent child to a person other than you if an order providing for the appointment of a possessory or managing conservator of the dependent child has been issued by a court. The person must provide us with written notice that he or she is a possessory or managing conservator of the dependent child on whose behalf the claim is made and a certified copy of the court order designating that individual as the possessory or managing conservator of the dependent child, or any other evidence that the person is eligible to receive benefits for the dependent child.

Recovery of overpayment
We have the right to recover from you or the recipient of benefits, any benefit amount paid that we determine to be an overpayment under this certificate. You or the recipient of benefits has the obligation to refund to us any amount of overpayment.

If benefits are overpaid on any claim, you or the recipient of benefits must refund us within 90 days. If the refund is not made in a timely manner, we have the right to offset future benefits payable under this certificate by an amount equal to the overpayment.

Beneficiary
If you die before the claim is paid, benefits will be paid to your assignee, or in the absence of an assignee, your estate.

Payment to Texas Health and Human Services Commission
We will pay benefits to the Texas Health and Human Services Commission on behalf of an insured child upon written notice to us if:

(1) you are required to pay child support by a court order issued in Texas or is not entitled to possession or access to the insured child and is required by court order to pay child support;
(2) the Texas Health and Human Services Commission is paying benefits on behalf of the insured child on behalf of the insured child under Chapter 31 and 32 of the Texas Human Resources Code; and
(3) notification is given to us in writing with a submitted claim that such benefits should be paid directly to the Texas Health and Human Services Commission.

ADDITIONAL INFORMATION

Changes to policy or certificate
We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Contestability
If an insured experiences a loss within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, which affects the risks assumed, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two-year period will be extended by fraud or as otherwise allowed by applicable laws.

Maintaining records
The policyholder is required to maintain adequate records of any information necessary for us to administer the policy and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

Clerical or administrative errors
If a clerical or administrative error is made in keeping records on or administering the insurance under this certificate, it will not affect otherwise valid insurance.

A clerical or administrative error, however, does not continue insurance which is otherwise stopped, make insurance effective when it should not have been, or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts put into effect as a result of a clerical or administrative error. If an error causes a change in premium payment, a fair adjustment will be made.

Misstatement of age
If an insured's age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

Conformity of state laws
The provisions of this certificate will conform to state law. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

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

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

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

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

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

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

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

For questions about insurance, contact:

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

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

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

Securian Life Insurance Company • A Stock Company

400 Robert Street North • St. Paul, Minnesota 55101-2098

GROUP HOSPITAL INDEMNITY CERTIFICATE OF INSURANCE • NONPARTICIPATING