

Certificate of Group Hospital Indemnity Insurance



Liberty Insurance
Underwriters Inc.

LIBERTY INSURANCE UNDERWRITERS INC.
(A Stock Insurance Company, hereinafter "Liberty")
175 Berkeley Street, Boston, MA 02116

Liberty certifies that certain **Eligible Persons** are insured for the benefits described in this Certificate. This insurance coverage is subject to the eligibility and effective date requirements described in the Eligibility and Effective Date section of this Certificate and to the terms and conditions of the Policy, and continuation of the Policy in force.

IMPORTANT NOTICE

This Certificate is evidence of **Your** insurance coverage and that of any **Covered Dependent** under the Policy.

The Policy is a contract between Liberty and the **Policyholder**. It may be modified or terminated without notice to, or the consent of, **You** or any **Covered Person**. This Certificate replaces any certificate previously issued by Liberty to **You**.

Liberty is providing this Certificate at the request of the **Policyholder**. The **Policyholder** maintains the Policy, which includes a copy of this Certificate. The **Policyholder** will make the Policy available for **You** to review and copy, upon request. If there is any conflict between this Certificate and the Policy, the Policy will control in all respects.

RIGHT TO EXAMINE CERTIFICATE

You have the right to examine the insurance coverage provided under this Certificate. If, for any reason, **You** are not satisfied with the insurance coverage, **You** must notify **Us** in writing within 31 days after the **Coverage Effective Date** that **You** do not want to keep the insurance coverage. When **We** receive **Your** notice, **We** will consider the Certificate void as though it was never issued and any premium **You** paid will be refunded. If **You** have received payment for any claim under this Certificate, **You** will be deemed to have accepted the Certificate.

NOTICE: THIS IS HOSPITAL INDEMNITY INSURANCE COVERAGE. THE POLICY PROVIDES LIMITED BENEFITS.

THIS IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE COVERAGE. THE POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ILLNESS ONLY.

THIS COVERAGE MAY NOT BE SOLD TO AN INDIVIDUAL WHO DOES NOT HAVE MINIMUM ESSENTIAL COVERAGE.

**PLEASE READ THIS CERTIFICATE CAREFULLY
A PRE-EXISTING CONDITION LIMITATION MAY APPLY.**

**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE COVERAGE.
If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Liberty.**

The Policy is renewable at the option of the Company. The Policy may be cancelled by the Company.
Please read the Policy and this Certificate for more information.

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SCHEDULE OF BENEFITS

Policyholder Name: Emergency Management Alliance

Policy Number: GHI05218559

Certificate Number: GHI05218559 – All Plans

Governing Jurisdiction is Tennessee and subject to the laws of that State.

Type of Insurance Coverage:

Insurance Coverage for **You**

Insurance Coverage for **You** and **Your Spouse**

Insurance Coverage for **You** and **Your Dependent Children**

Family Coverage: Insurance Coverage for **You, Your Spouse, and Your Dependent Children**

Plan Choice Selected by Your Employer by You: Plan 1

The Certificate includes a Schedule of Insurance for Plan 1. Only the **Schedule of Benefits** for the Plan that **You** selected will apply to insurance coverage under this Certificate for **You** and any **Dependents**.

Benefit Waiting Period	30 days following the Coverage Effective Date for an Illness
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HOSPITAL CONFINEMENT

Incurral Period	90 days of a Covered Accident
Hospital Confinement Benefit Amount	\$100 per Day
Hospital Confinement Maximum	31 Days per Confinement
Hospital Confinement Benefit Maximum	60 Days per Policy Year

HOSPITAL INTENSIVE CARE

Incurral Period	90 days of a Covered Accident
Hospital Intensive Care Benefit Amount	\$200 per Day
Hospital Intensive Care Benefit Confinement Maximum	31 Days per Confinement
Hospital Intensive Care Benefit Maximum	60 Days per Policy Year

HOSPITAL ADMISSION

Incurral Period	90 days of a Covered Accident
Hospital Admission Benefit Amount	\$500 per Admission
Intensive Care Unit Admission Benefit Amount	\$1000 per Admission

Hospital Admission Benefit Maximum

1 per **Policy Year**

EMERGENCY ROOM

Incurral Period

48 hours of a **Covered Accident**

Emergency Room Benefit Amount

\$100 per **Day**

Emergency Room Benefit Maximum

2 Days per Policy Year

DEFINITIONS

Certain words and terms used in the Policy and in this Certificate have specific meanings. When capitalized and bolded within the text of the Policy or this Certificate, these words and terms have the meanings set forth below. He, His, and Him refer to any individual, regardless of gender.

Active Member	means a Member in good standing according to the rules of the Policyholder .
Admission or Admitted	means the Covered Person is accepted for Inpatient services in a Hospital or Intensive Care Unit .
Age	means a Covered Person's age attained on the Coverage Effective Date for him under the Policy. Thereafter, it is his age attained during the last Policy Year .
Ambulatory Surgical Facility	means a licensed surgical center that operates exclusively for the purpose of providing surgical services and that has permanent facilities and equipment to perform surgical procedures on an Outpatient basis. An Ambulatory Surgical Facility may be a freestanding facility or a distinct unit of a Hospital . An Ambulatory Surgical Facility does not have Inpatient accommodations.
Benefit Waiting Period	means a time period following the Coverage Effective Date or reinstatement date (if applicable) of the Policy during which benefits are not payable. The Benefit Waiting Period for an Illness is listed in the Schedule of Benefits .
Business Associate	means an individual who, within the six month period prior to the date of the Covered Accident , either shared ownership of a medical practice or shared office space with the Covered Person .
Certificateholder (You)	means an Eligible Person for whom an application, enrollment, or other form has been accepted by Liberty and the required premium has been paid when due, and for whom insurance coverage under the Policy remains inforce.
Child or Children	means Your biological children, stepchildren, adopted children, foster children, or any child for whom You are the legal guardian or are required by a court or administrative order to provide insurance coverage. In this certificate, Children may refer to one Child .
Complications of Pregnancy	means conditions whose diagnoses are distinct from pregnancy but are adversely affected by or are caused by pregnancy, including acute nephritis; nephrosis; cardiac decompensation; missed abortion; similar medical and surgical conditions of comparable severity; non-elective cesarean section; ectopic pregnancy, which is terminated; and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy does not include false labor, occasional spotting, Physician -prescribed rest during pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy but not constituting a medically classifiable distinct complication of pregnancy. Complications of Pregnancy will be covered under the Policy as any other Illness .
Confined or Confinement	means the assignment to a bed as a resident Inpatient in a Hospital or Intensive Care Unit on the advice of a Physician for a period of no less than 23 continuous hours. Confined or Confinement also includes the

assignment to a bed as a resident **Inpatient** in a **Rehabilitation Facility** or **Skilled Nursing Facility**.

Confinement for the same or related **Injury** or **Illness** within 30 days of discharge from a previous **Confinement** is considered a continuation of the previous **Confinement**.

Coverage Effective Date	Your Coverage Effective Date is described in the Eligibility and Effective Date provision. The Coverage Effective Date for Your Spouse and/or Dependent Children is the date their insurance coverage becomes effective according to the Eligibility and Effective Date provision.
Covered Accident	means a sudden, unexpected, specific and abrupt event that is external to the body and occurs by chance at an identifiable time and place that: <ol style="list-style-type: none">1. Occurs on or after the Coverage Effective Date;2. Occurs while insurance coverage for the Covered Person under the Policy is inforce; and3. Is not otherwise excluded under the terms of the Policy.
Covered Dependent	means Your Spouse and/or Dependent Children for whom You have elected insurance coverage and for whom coverage has become effective under Your Certificate.
Covered Person	means the individual(s) for whom the required premium has been paid when due and for whom insurance coverage under the Policy remains inforce. Covered Person includes Covered Dependents .
Day	means a continuous 24 hour period, which begins once treatment has begun. Treatment that begins on one calendar day and ends on the following calendar day will be considered one Day unless the treatment has extended for a period of more than 24 hours.
Dependent	means Your Spouse and/or Dependent Children .
Dependent Children	means all of Your Children who are unmarried and under 26 years of age. However, if any Dependent Child is incapable of self-sustaining employment due to intellectual or physical disability and is dependent on You for support, such Age limit shall not apply. Proof of such incapacity and dependency must be furnished to Us within 31 days following the Child's 26 th birthday, and not more frequently than annually following the two year period after the Dependent Child attains the limiting age.
Domestic Partner	means an unmarried person of the same or opposite sex with whom You share a committed relationship and who, with You , are jointly responsible for each other's welfare and financial obligations, have shared the same residence for a period of at least 12-24 consecutive months immediately preceding the Coverage Effective Date , and each of whom are at least 18 years of age and mentally competent to consent to a contract, not related by blood to a degree that could prohibit legal marriage in the state where they legally reside, and are not married to or legally separated from anyone else. A Domestic Partner certification must be completed and filed with the Policyholder before the partner can be designated as a Covered Person .
Eligible Person	means an individual who is part of an Eligible Class as stated in the Policy Schedule and has met the Eligibility Waiting Period in that Schedule.
Eligibility Waiting Period	means the number of continuous days that the Member must be an Active Member in an Eligible Class as shown in the Policy Schedule.

Emergency Room	means a specified area of a Hospital that: <ol style="list-style-type: none"> 1. Is dedicated to the provision of emergency care; 2. Is staffed and equipped to handle trauma; 3. Is supervised by and provides treatment and care by Physicians; and 4. Provides care 24 hours per day, 7 days per week.
Enrollment Period	means the period designated by the Policyholder and Liberty during which an Eligible Person may enroll for insurance coverage.
Evidence of Insurability	means a statement of Your and any Dependent's medical history, on a form provided by Liberty, upon which acceptance for insurance coverage will be determined by Liberty.
Family Coverage	means insurance coverage in force under the Policy on Your Spouse and Dependent Children : <ol style="list-style-type: none"> 1. Whom You have elected to cover under the Policy; and 2. For whom the required premium has been paid.
Family Status Change	means any one of the following events that may occur: <ol style="list-style-type: none"> 1. Your marriage or divorce or legal separation; 2. Your filing or rescinding of a Domestic Partner certification; 3. The birth of a Child to You; 4. The adoption of a Child by You; 5. The death of Your Spouse or Child; 6. The commencement or termination of employment of Your Spouse; 7. The change from part-time employment to full-time employment by You or Your Spouse; 8. The change from full-time employment to part-time employment by You or Your Spouse; or 9. The taking of unpaid leave of absence by You or Your Spouse.
Hospital	means an institution that meets all of the following: <ol style="list-style-type: none"> 1. Is licensed as a hospital pursuant to applicable law; 2. Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons; 3. Is managed under the supervision of a staff of medical doctors; 4. Provides 24-hour nursing services by or under the supervision of a registered nurse (R.N.); 5. Has medical, diagnostic, and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and 6. Charges for its services. <p>The term Hospital does not include a clinic, facility, or unit of a hospital for:</p> <ol style="list-style-type: none"> 1. Rehabilitation; 2. Convalescent care; 3. Custodial care; 4. Educational purposes; 5. Skilled or nursing care; 6. The aged; 7. The treatment of drug addiction or alcoholism; or 8. Mental or nervous disorders.

Illness	means an illness or disease that manifests itself after the Covered Person's Coverage Effective Date and that requires treatment by a Physician .
Immediate Family Member	means a person who is related to the Covered Person , or a Dependent 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 step-parent), grandparent (includes step-grandparent), brother or sister (includes step-brother or step-sister, half-brother or half-sister), or child (includes legally adopted or step-child).
Incurral Period	means the number of days immediately following a Covered Accident as shown in the Schedule of Benefits. The Incurral Period may be different for each benefit.
Injury	means an accidental bodily injury that is the direct result, independent of all other causes, from a Covered Accident (independent of sickness, disease, mental incapacity, bodily infirmity, or any other causes).
Inpatient	means Confined overnight as a registered resident bed patient in a Hospital, or Rehabilitation Facility, or Skilled Nursing Facility where at least one day's room and board is charged. The Confinement must be on the advice of a Physician .
Intensive Care Unit or ICU	<p>means a distinct unit of a Hospital that:</p> <ol style="list-style-type: none"> 1. Is restricted to patients who are critically ill or injured and who require intensive, comprehensive monitoring and care; 2. Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement; 3. Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; 4. Is under close observation by a specially trained nursing staff assigned exclusively to the unit on a 24-hour basis; and 5. Has a Physician assigned to it on a full-time basis. <p>The term Intensive Care Unit includes Hospital units with the following names: Intensive Care Unit; Coronary Care Unit; Neonatal Intensive Care Unit; Pulmonary Care Unit; Burn Unit; or Transplant Unit.</p>
Member	means an individual who is a person who meets all of the conditions of membership of a Policyholder .
Member of the Same Household	means a person who maintains residence at the Primary Address of the Covered Person .
Outpatient	means medical treatment received without being Admitted or Confined to a Hospital .
Physician	<p>means an individual who:</p> <ol style="list-style-type: none"> 1. Is licensed as a doctor in the jurisdiction where the services are being performed; 2. Is legally qualified to practice medicine; and 3. Renders care and treatment to the Covered Person that is appropriate for the condition and which is within the scope of the license. <p>Physician does not include a person providing homeopathic, aromatherapeutic, or herbal therapeutic services.</p>
Policy Year	means each one year period beginning with Your Coverage Effective Date . Each anniversary of Your Coverage Effective Date begins a new Policy Year . All of Your Covered Dependent(s) will have the same

Policy Year as You, even if they have a different **Coverage Effective Date** than **You**.

Policyholder means the entity, named as the **Policyholder** on the **Schedule of Benefits**, to which Liberty issues the Policy.

Premium Due Date means the date premiums are due to Liberty.

Primary Address means the dwelling where a person maintains residence for the majority of the time, whether the person owns or rents the dwelling.

Rehabilitation Facility means an institution that:

1. Provides rehabilitation care services on an **Inpatient** basis;
2. Is licensed as a rehabilitation facility pursuant to applicable law;
3. Is a separate facility within a **Hospital**, a distinct unit of another facility and physically separated from the rest of such facility, or a freestanding facility; and
4. Is supervised by or under the direction of a **Physician**.

A **Rehabilitation Facility** is not a place mainly for care for the aged, a retirement home, a rest home, a community living center, or a place mainly for the treatment of alcoholism, mental illness, or drug abuse. A **Rehabilitation Facility** is not a **Skilled Nursing Facility**.

Schedule of Benefits means the **Schedule of Benefits** found at the beginning of this Certificate.

Skilled Nursing Facility means an institution that:

1. Provides a level of care greater than can be provided at the **Covered Person's** home following a **Covered Accident** or **Illness**;
2. Is licensed as a skilled nursing facility pursuant to applicable law;
3. Is a separate facility within a **Hospital**, a distinct unit of another facility and physically separated from the rest of such facility, or a freestanding facility; and
4. Provides nursing care on a 24-hour basis by full-time registered nurses to individuals who are not able to care for themselves due to an **Injury** or **Illness**; and
5. Is supervised by or under the direction of a **Physician**.

A **Skilled Nursing Facility** is not a place mainly for care for the aged, a retirement home, a rest home, a community living center, or a place mainly for the treatment of alcoholism, mental illness, or drug abuse. A **Skilled Nursing Facility** is not a **Rehabilitation Facility**.

Spouse means **Your** legal spouse. **Your Domestic Partner** will be covered on the same basis as a **Spouse** unless prohibited by state law.

Surgery means medical procedures involving cutting of body tissue, debridement or permanent joining of body tissue for repair of wounds, treatment of fractured bones or dislocated joints, or endoscopic procedures that are performed in a **Hospital** or **Ambulatory Surgical Facility**. **Surgery** typically requires general anesthesia that is administered by a nurse anesthetist or a licensed anesthesiologist unless the type of procedure ordinarily requires the **Covered Person** to be awake to assist in the performance of the procedure while the **Surgery** is being performed.

We, Us, Our means Liberty Insurance Underwriters Inc.

You, Your means the **Certificateholder**.

ELIGIBILITY AND EFFECTIVE DATE

Eligible Class of Persons

A person may not be insured as a **Covered Dependent** and as a **Certificateholder** under this Policy.

Class 1: All **Active Members** of the **Policyholder**.

Eligibility Requirements for Insurance Coverage

Member Eligibility Date for Insurance Coverage:

The date the **Member** becomes an **Eligible Person**.

Dependent Eligibility Date for Insurance Coverage:

If **You** are in an Eligible Class for **Dependent** insurance coverage **You** may enroll **Your Dependents**:

1. At the time **You** enroll;
2. During an enrollment period; or
3. Upon a **Family Status Change**.

A person may not be insured as a **Covered Dependent** and as a **Certificateholder** under the Policy.

Effective Date for Insurance Coverage

Insurance coverage will be effective at 12:01 a.m. in the Governing Jurisdiction shown in the Schedule of Benefits on the day determined as follows:

Employee Coverage Effective Date:

An **Eligible Person's** insurance coverage becomes effective on the first day of the month following the latest of the following dates:

1. **Your** Eligibility Date if **You** have enrolled for insurance coverage;
2. The date **You** enroll for insurance coverage other than an annual **Enrollment Period**;
3. The first day of the next **Policy Year** if **You** enrolled during an annual **Enrollment Period**.

Dependent Coverage Effective Date:

A **Dependent's** insurance coverage becomes effective on the first day of the month following the latest of the following dates:

1. **Your** Eligibility Date if **You** have enrolled for insurance coverage;
2. The date **You** enroll **Your Dependents** for insurance coverage other than an annual **Enrollment Period**;
3. The first day of the next **Policy Year** if **You** enrolled **Your Dependents** during an annual **Enrollment Period**.

Dependent Coverage for Newborn or Adopted Child; Effective Date

Your Dependent Children who are born or placed in **Your** home for adoption while **You** are covered under the Policy are covered for 31 days from the moment of live birth or adoption date of placement.

If **You** do not have **Dependent Children** insurance coverage at the time of the birth or adoption date of placement, **You** must notify **Us** within 31 days of the newly eligible **Dependent Child's** birth or adoption

date of placement and pay the required additional premium for **Your Dependent Children's** insurance coverage to continue beyond 31 days.

Once **Dependent** insurance coverage is in effect for at least one **Dependent Child**, any additional child who becomes **Your Dependent Child** will be insured from the date the child becomes **Your Dependent Child**. **You** do not need to enroll such additional **Dependent Children** for them to become insured for **Dependent** insurance coverage.

Re-Enrollment Period

During each Re-Enrollment Period, **You** may keep **Your** insurance coverage at the same level or increase or decrease **Your** insurance coverage.

Increases and decreases will be effective as of the next **Calendar Policy Year**.

If **You** do not enroll for a change in **Your** insurance coverage option during any Re-Enrollment Period **You** will continue to be insured for the same coverage option during the next **Policy Year**, and may not change **Your** insurance coverage unless **You** experience a **Family Status Change**.

Family Status Change

If **You** experience a **Family Status Change**, **You** may keep **Your** insurance coverage at the same level or increase or decrease **Your** insurance coverage.

You must apply for the change in insurance coverage within 31 days of the date of the **Family Status Change**. Such changes in insurance coverage must be due to or consistent with the reason for the **Family Status Change**. A change in insurance coverage is consistent with a **Family Status Change** only if it is necessary or appropriate as a result of the **Family Status Change**.

Delayed Effective Date for Employee Insurance Coverage

The **Coverage Effective Date** of any initial, increased, or additional insurance coverage will be delayed for an individual if he is not an **Active Member** because of **Injury** or **Illness**. The initial, increased, or additional insurance coverage will begin on the date the individual is an **Active Member**.

Delayed Effective Date for Spouse Insurance Coverage

If a **Spouse** is **Confined** in a **Hospital, Skilled Nursing Facility, or Rehabilitation Facility**, on the date any initial, increased, or additional insurance coverage is to take effect, such insurance coverage will take effect only when the **Confinement** or residency ends.

If a **Spouse** has applied for or is receiving disability benefits of any kind, insurance coverage will take effect when the disability has ended.

TERMINATION

Termination Date of Your Insurance Coverage

Your insurance coverage under the Policy will terminate on the earliest of the following dates:

1. The **Premium Due Date**, if premiums are not paid when due, subject to the Premiums provision;
2. The date the Policy terminates;
3. The end of the **Policy Year** in which **You** attain **Age 70**;
4. At the end of the month following The date **You** cease to be a member of an Eligible Class as stated on the Policy Schedule;
5. The date **We** receive written instructions from **You** to discontinue **Your** insurance coverage under the Policy; or
6. The date **You** die.

Termination of insurance coverage will not affect a claim that was incurred while **Your** coverage was in force under the Policy.

Termination Date for Your Dependent

A **Covered Dependent's** insurance coverage under the Policy will terminate on the earliest of the following dates:

1. The date **Your** insurance coverage under the Policy ends;
2. The date the person ceases to qualify as a **Dependent** or for a **Spouse**, the end of the **Policy Year** in which the **Spouse** attains **Age 70**;
3. The **Premium Due Date**, if premiums are not paid when due (subject to the Premiums provisions);
4. The date **You** are no longer eligible for **Dependent** insurance coverage;
5. The date **Dependent** insurance coverage is no longer provided by the Policy;
6. The date **We** receive written instructions from **You** to discontinue **Dependent** insurance coverage;
7. The date the Policy terminates; or
8. The date **Your Dependent** dies.

Termination of insurance coverage will not affect a claim that was incurred while **Your Dependent** insurance coverage was in force under the Policy.

Extension of Hospital Confinement and Hospital Intensive Care Benefits

If a **Covered Person** is **Confined** to a **Hospital** or **Intensive Care Unit** on the date his insurance coverage terminates, **We** will continue to pay the applicable Confinement Benefit, in accordance with the benefits in effect at the time the **Covered Person's** insurance coverage terminates, for such **Confinement** until the earliest of:

1. the date the **Covered Person** is discharged from the **Hospital** or **Intensive Care Unit**;
2. The applicable benefit maximum is reached; or
3. 12 months after the date the **Covered Person's** insurance coverage terminates.

BENEFITS AND COVERAGES

This section describes the benefits provided by the Policy. Benefit amounts, benefit periods, and any applicable aggregate and benefit-specific maximums are shown in the **Schedule of Benefits**. These Benefits and Coverages are subject to the terms, conditions, exclusions, and limitations contained in the Policy and any specific terms, conditions, and limitations applicable to the specific Benefit or Coverage. Benefits are payable only while a **Covered Person** is insured under the Policy. Benefits are not payable for any **Illness** that occurs before the end of any applicable **Benefit Waiting Period** shown in the **Schedule of Benefits**.

HOSPITAL CONFINEMENT

If a **Covered Person** is **Confined** in a **Hospital** for treatment of an **Injury** or **Illness**, **We** will pay the Hospital Confinement Benefit Amount for each **Day** of **Confinement** as shown in the **Schedule of Benefits**, subject to the following:

1. **Confinement** for treatment of an **Injury** must commence within the **Incurral Period** shown in the **Schedule of Benefits**;
2. **We** will not pay more than one Hospital Confinement Benefit for each **Day** of **Confinement**, regardless of whether the **Confinement** is caused by more than one **Injury** or **Illness**;
3. If the **Covered Person** is eligible for both a Hospital Confinement Benefit and a Hospital Intensive Care Benefit for the same **Day** of **Confinement**, **We** will pay only the larger of the two benefits;
4. The maximum number of **Days** for which **We** will pay a Hospital Confinement Benefit for each period of **Confinement** is the Hospital Confinement Maximum listed in the **Schedule of Benefits**; and
5. The maximum number of **Days** for which **We** will pay is the Hospital Confinement Benefit Maximum as shown in the **Schedule of Benefits**.

HOSPITAL INTENSIVE CARE

If a **Covered Person** is **Confined** in an **Intensive Care Unit** for treatment of an **Injury** or **Illness**, **We** will pay the Hospital Intensive Care Benefit Amount for each **Day** of **Confinement** as shown in the **Schedule of Benefits**, subject to the following:

1. **Confinement** for treatment of an **Injury** must commence within the **Incurral Period** shown in the **Schedule of Benefits**;
2. **We** will not pay more than one Hospital Intensive Care Benefit for each **Day** of **Confinement**, regardless of whether the **Confinement** is caused by more than one **Injury** or **Illness**;
3. If the **Covered Person** is eligible for both a Hospital Confinement Benefit and a Hospital Intensive Care Benefit for the same **Day** of **Confinement**, **We** will pay only the larger of the two benefits;
4. The maximum number of **Days** for which **We** will pay a Hospital Intensive Care Benefit for each period of **Confinement** is the Hospital Intensive Care Maximum listed in the **Schedule of Benefits**; and
5. The maximum number of **Days** for which **We** will pay is the Hospital Intensive Care Benefit Maximum listed in the **Schedule of Benefits**.

HOSPITAL ADMISSION

If a **Covered Person** is **Admitted** to a **Hospital** or **Intensive Care Unit** for treatment of an **Injury** or **Illness**, **We** will pay the Hospital Admission Benefit Amount shown in the **Schedule of Benefits** subject to the following:

1. **Admission** for treatment of an **Injury** must occur within the **Incurral Period** shown in the **Schedule of Benefits**;
2. If the **Covered Person** is **Admitted** to the **Hospital** and the **Intensive Care Unit** during the same **Confinement**, **We** will pay only the larger of the two benefits;
3. If a **Covered Person** is **Admitted** to a **Hospital** but is not **Admitted** to an **Intensive Care Unit**, we will pay the Hospital Admission Benefit. If the **Covered Person** is **Admitted** to an **Intensive Care Unit**, we will pay only the Intensive Care Unit Admission Benefit Amount;
4. The maximum number of **Hospital Admissions** for which **We** will pay is the Hospital Admission Benefit Maximum listed in the **Schedule of Benefits**.; This limit applies to both **Hospital Admissions** and **Intensive Care Admissions** combined.;
5. **We** will not pay the Hospital Admission Benefit if the **Covered Person** is treated solely in an observation unit, **Emergency Room**, or on an **Outpatient** basis.

EMERGENCY ROOM

If a **Covered Person** receives treatment in an **Emergency Room** for an **Injury** or **Illness**, **We** will pay the Emergency Room Benefit Amount for each **Day** of treatment as shown in the **Schedule of Benefits**, subject to the following:

1. Treatment of an **Injury** must occur within the **Incurral Period** shown in the **Schedule of Benefits**; and
2. The maximum number of **Days** for which **We** will pay is the Emergency Room Benefit Maximum listed in the **Schedule of Benefits**.

LIMITATIONS

PRE-EXISTING CONDITION LIMITATION

Pre-Existing **Injury** or **Illness** means:

1. The existence of a condition or symptom that would cause a reasonable person to seek medical advice, care, or treatment within the 12 month period before the **Covered Person's Coverage Effective Date**; or
2. A condition or symptom for which medical advice, care, or treatment was recommended by or received from a **Physician** within the 12 month period before the **Covered Person's Coverage Effective Date**, regardless of whether such advice, care, or treatment was followed by the **Covered Person**.

We will not pay benefits arising from, caused by, contributed to, or resulting from a pre-existing **Injury** or **Illness** unless it occurs more than 12 months after the **Covered Person's Coverage Effective Date**.

CHILDBIRTH LIMITATION

We will not pay any benefits due to any **Covered Person's** giving birth within the first 10 months after the **Covered Person's Coverage Effective Date** as a result of a pregnancy. **Complications of Pregnancy** will be covered under the Policy as any other **Illness**.

EXCLUSIONS

In addition to any benefit-specific exclusions, **We** will not pay benefits for any claim which directly or indirectly, in whole or in part, is caused by, contributed to, or results from any of the following unless insurance coverage is specifically provided for by name in the Benefits and Coverages section:

1. Declared or undeclared war or act of war or any act of declared or undeclared war;
2. The **Covered Person's** intentionally self-inflicted injury, suicide, or any attempt while sane or insane, or intentional restriction of oxygen to the brain;
3. The **Covered Person's** active duty service in the military, naval, or air force of any country or international organization. Upon **Our** receipt of proof of service, **We** will refund any premium paid for this time. Military Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
4. The **Covered Person's** flight in, boarding, or alighting from an aircraft or any craft designed to fly above the Earth's surface except as a fare-paying passenger on a regularly scheduled commercial airline or on an aircraft owned or leased by the **Policyholder**;
5. Dental or plastic **Surgery** except when such **Surgery** is performed to:
 - a) Treat an **Injury**;
 - b) Correct a disorder of normal bodily function; or
 - c) Reconstruct a part of the body which was disfigured or removed as a result of an **Injury** or **Illness**;
6. The treatment of a **Covered Person's** mental illness;
7. The treatment of a **Covered Person's** alcoholism, drug addiction, chemical dependency, or complications thereof;
8. The **Covered Person's** commission of, or attempt to commit, a felony, or engagement in an illegal occupation;
9. The **Covered Person's** operation of a motor vehicle while intoxicated which will be conclusively assumed if he is operating the motor vehicle with a blood alcohol level in excess of the amount allowed under the laws of the state in which the accident occurred;
10. The **Covered Person's** intoxication, or voluntary ingestion, including inhalation, snorting, inserting, or otherwise consuming any narcotic or drug unless prescribed or taken under the direction of a **Physician**, and taken in accordance with the prescribed dosage, or an "over the counter" drug not taken in accordance with the prescribed dosage;
11. The **Covered Person's** voluntary ingestion, including inhalation, snorting, inserting, or otherwise consuming of poison, gas, or fumes;
12. The **Covered Person's Injury** sustained while participating in professional or semi-professional athletics;
13. The **Covered Person's** participation in any motorized race or contest of speed or stunt show;
14. The **Covered Person's** travel outside the United States and its possessions for the sole purpose of receiving medical care or treatment;
15. Any **Hospital Confinement** of a newborn following the birth unless the newborn is sick or injured;
16. The **Covered Person's Injury** incurred prior to the **Coverage Effective Date**;
17. The **Covered Person's Illness** incurred prior to the **Coverage Effective Date** or during any applicable waiting period;
18. The **Covered Person's** treatment related to gender reassignment surgery or gender identity disorder, voluntary sterilization or reversal of sterilization, in vitro fertilization, embryo transfer procedures, and artificial insemination;
19. The **Covered Person's** treatment through experimental procedures;
20. Routine health examinations or procedures;
21. The **Covered Person's** commission of or active participation in a riot or insurrection;
22. Services or treatment rendered by any person who is:
 - a) The **Covered Person**;
 - b) A **Member** of the **Same Household**;
 - c) An **Immediate Family Member** of the **Covered Person**; or
 - d) A **Business Associate** of the **Covered Person**.

CLAIM PROVISIONS

Notice of Claim

Notice of claim must be given to **Us** within 30 days following the occurrence or start of an event which is covered under the Policy. If that is not possible, **We** must be notified as soon as it is reasonably possible to do so. Such notice of claim must be received in a form or format satisfactory to **Us**, including such identifying information that **We** may request. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form.

When applicable, within 15 days of receiving a notice of claim, **We** will send **You** the claim forms. If **You** do not receive the forms within 15 days after notice of claim is provided, **You** may begin to submit written Proof of Loss without waiting for the claim forms.

Proof of Loss

Proof of Loss means the documentation that supports a claim. This information is often found in standardized medical documents and typically includes medical records and a statement by a treating physician.

Satisfactory Proof of Loss must be given to **Us** within 30 days of the date of the occurrence or start of an event covered under the Policy.

Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if it was not reasonably possible to do so. **We** will not accept Proof of Loss any later than one year and three months after the date of the occurrence or start of an event covered under the Policy, except in the absence of **Your** legal capacity.

In addition, **We** may require authorizations to obtain medical and psychiatric information as well as non-medical information.

Physical Examination and Autopsy

We may have a **Covered Person** examined as often as reasonably necessary while a claim is pending. In the case of death, **We** may also require an autopsy, unless prohibited by law. **We** will cover all costs for physical examinations or autopsy if required by **Us**.

Time of Payment of Claims

Benefits payable under the Policy will be paid after **We** receive satisfactory Proof of Loss and a completed claim form. **We** shall have discretionary, final, and binding authority to make all determinations regarding claims for benefits under the Policy, which shall include, but not be limited to, decisions of eligibility for insurance coverage or benefits, the amount of any benefits due, and the interpretation of the terms of the Policy.

We will pay or deny claims immediately upon receipt of all information **We** require to properly adjudicate the claim.

Payment of Claim

Benefits will be paid to **You**, or **Your** legally appointed guardian if **You** are not legally able to accept such benefits. Benefits will be paid to **Your** estate, in the event any payment is owed at the time of **Your** death. **We** will be discharged to the extent of any such payment made in good faith.

Legal Action

The **Employee** or claimant cannot take legal action against **Us** for benefits under the Policy:

1. Within 60 days after he has sent **Us** written Proof of Loss; or
2. More than three years from the time written proof is required to be given.

Economic Sanctions

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the Company from providing insurance, including, but not limited to, the payment of claims.

Recovery of Overpayment

If benefits are overpaid, **We** have the right to recover the amount overpaid by either of the following methods within 18 months after such overpayment was made:

1. A request for lump sum payment of the overpaid amount; or
2. A reduction of any amounts payable under the Policy.

If there is an overpayment due when **You** die, **We** may recover the overpayment from **Your** estate.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Policy are not assignable, except as required by law or as permitted by Liberty. This insurance coverage may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

Clerical Error

A person's insurance coverage will not be affected by error or delay in keeping records of insurance coverage under the Policy.

Entire Contract

Your insurance coverage is provided under the terms of a group hospital indemnity insurance policy. This Certificate, the Policy, the application, or other forms signed by **You**, the **Policyholder's** application, and any endorsements to or amendments of the Policy constitute the entire contract.

Examination of the Policy

The Policy will be available for inspection at the **Policyholder's** office during regular business hours.

Incontestability

Subject to the Policy's Incontestability provision, after a **Covered Person** has been insured under the Policy for two years from the **Coverage Effective Date**, no statement made by the **Covered Person**, except a fraudulent one, will be used to contest a claim incurred under the Policy after the two-year period. Liberty may only contest insurance coverage if the misstatement is made in a written instrument signed by the **Covered Person** and a copy is given to the **Covered Person**.

Misstatement of Fact or Age

If the **Policyholder** or **Certificateholder** has misstated any fact, all amounts payable under the Policy will be determined as if such fact had been correctly stated, to the extent that the appropriate premium was paid.