

RELIANCE STANDARD

LIFE INSURANCE COMPANY

Home Office: Schaumburg, Illinois • Administrative Office: Philadelphia, Pennsylvania

GROUP HOSPITAL INDEMNITY BENEFIT POLICY

This is a contract between us, **RELIANCE STANDARD LIFE INSURANCE COMPANY**, and **Unified School District 495 Fort Larned**, (the Contract Holder).

Policy Number: **VHI000536**

Policy Effective Date: **October 1, 2020**

Policy Anniversary Date: **October 1**

Policy Term: This policy will go into effect on the Policy Effective Date. All periods of insurance for a Covered Person begin and end at 12:01 A.M. Standard Time at the Contract Holder's address. Unless this policy is ended by the Contract Holder or us (see "Termination of Policy" in GENERAL PROVISIONS), it may be renewed by payment of the required premiums, at the rates in effect on each premium due date.


Scope of Coverage: In exchange for the payment of premiums, as described in PREMIUMS, we agree to pay benefits to all eligible persons covered for benefits for losses caused by:

- a) Injury, directly and with no other cause; and
- b) Sickness.

This coverage is subject to the exclusions, and to all of the other terms of this policy. This policy will be governed by the laws of the state of Kansas.

IN WITNESS WHEREOF, we have signed this policy at Philadelphia, Pennsylvania.


Secretary


President

THIS POLICY PROVIDES LIMITED ACCIDENT & SICKNESS COVERAGE. IT IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT. READ THIS POLICY CAREFULLY

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SCHEDULE OF BENEFITS

1. ELIGIBILITY: Employees working 30 hours are eligible the first day of the month following 30 days

Dependent Coverage: Yes No

2. COVERAGE YEAR: Begins on October 1st and ends on September 30th of the following year.

3. COVERED EVENTS AND BENEFIT AMOUNTS:

Hospital Confinement Daily Income Benefit

| | |
|-----------------------------------|---------------------------|
| Daily benefit | <u>\$ 100 per day</u> |
| Maximum benefit per Coverage Year | <u>180 daily benefits</u> |

Hospital Admission Benefit

| | |
|--|-------------------------|
| A. Daily benefit per Hospital admission | <u>\$ 1,000 per day</u> |
| Maximum benefit per Coverage Year for admission listed under A | <u>1 daily benefit</u> |

4. INDIVIDUAL EFFECTIVE DATE: the following will apply to eligible employees of the Contract Holder and their eligible dependents.

Coverage will be effective the first day of the month following enrollment, provided the required premium is paid.

5. PREMIUMS:

Premium Payable: Monthly

| | | |
|-----------------|---------------------------|----------|
| Premium Amount: | Employee Only: | \$ 15.77 |
| | Employee Plus Spouse: | \$ 33.28 |
| | Employee Plus Child(ren): | \$ 23.66 |
| | Employee Plus Family: | \$ 41.16 |

GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event that causes Injury to a Covered Person.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985.

"Coverage Year" means the period of time described on the Schedule of Benefits.

"Covered Person" means any eligible person for whom coverage is in effect under the policy.

"Doctor" means any practitioner who is licensed under the Kansas healing arts act (or similar licensing law of the state in which treatment is received) and who is acting within the lawful scope of their license when performing the service for which claim is made.

"Eligible Dependents" means:

- a) the Insured's lawful spouse; and
- b) the Insured's eligible children who are less than age 26.

Eligible children include natural children, stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered.

"Hospital" means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these facilities; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, a facility for treatment of alcoholism or drug addiction, or a facility for treatment of mental disorders.

"Injury" means accidental bodily Injury of a Covered Person:

- a) caused by an Accident; and
- b) that results in covered loss directly and independently of all other causes.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

"Inpatient" means a Covered Person who has been formally admitted to a Hospital for purposes of receiving inpatient Hospital services for no less than 23 hours.

"Insured" means an employee for whom coverage is in effect under the policy.

"Medically Necessary" means the care, treatment or supply is:

- a) rendered for the diagnosis, treatment, cure or relief of a health condition, Sickness, Injury or its symptoms; and
- b) necessary for and appropriate to the diagnosis or treatment according to the attending medical care provider.

"Sickness" means illness or disease of a Covered Person that:

- a) is treated by a Doctor while the person is covered under the policy; and
- b) results directly and independently of all other causes in loss covered by the policy.

INDIVIDUAL EFFECTIVE DATES

Insured - Individual insurance will become effective as indicated on the Schedule of Benefits.

An eligible person may enroll only within 31 days after becoming eligible experiencing a qualified change in their family situation (e.g. a divorce, legal separation, death, marriage, or birth/adoption of a new child), or during an open enrollment period, unless otherwise indicated by the policy. Open enrollment period means a pre-determined term during which any eligible person who previously did not enroll for coverage under the policy may enroll for coverage.

If the policy is being issued as a replacement group policy without any gap in coverage, any eligible person who is confined to a hospital or otherwise disabled at the time such person's prior group policy terminates is eligible to be enrolled under the policy as of the Policy Effective Date. The payment of benefits under the policy, when it is intended to afford continuous coverage, will begin immediately following expiration of the prior group policy.

Dependents - Dependent insurance will become effective on the latest of:

- a) the Insured's effective date if the dependent is eligible as of the Insured's effective date and the Insured enrolls and pays premium for the dependent on or before that date; or
- b) if a dependent is not eligible as of the Insured's effective date, such dependent's coverage will be effective on the date they become eligible, provided the Insured enrolls and pays premium for the dependent within 31 days of the date the dependent becomes eligible; however, if a dependent is eligible as of the Insured's effective date but not enrolled, such dependent's coverage will be effective on the date the Insured enrolls and pays premium for the dependent provided that occurs within 31 days of the date the Insured experiences a qualified change to their family situation; or
- c) as provided on the Schedule of Benefits.

In no case will coverage for eligible dependents take effect before the Insured's.

Newborn Child Coverage: A child of the Insured born while the policy is in force is provided coverage for covered events rendered for Injury and Sickness (including covered events that are necessary to care and treat congenital defects, birth abnormality and premature birth), as well as those for routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth and the additional premium, if any, must be submitted to us within 31 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 31-day period.

Adopted Children Coverage: A minor child who comes under the charge, care and control of the Insured while the policy is in force is provided coverage for covered events rendered for Injury and Sickness, as long as the Insured files a petition to adopt. The coverage provided to such child will be the same as provided for other members of the Insured's family. Such child is covered from the date of placement in the Insured's home if the Insured applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage begins at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Coverage for such child will continue unless the petition for adoption is dismissed or denied.

INDIVIDUAL TERMINATION DATES

Insured - Coverage for an Insured will end on the earliest of:

- a) the date the Insured is no longer eligible unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid; or

- b) any premium due date, if full payment for the Insured's coverage is not made within 31 days following the premium due date; or
- c) the date that the policy terminates; or
- d) the date the Insured enters an armed service on full-time active duty. Premium will be returned on a pro-rata basis if the Contract Holder notifies us in writing.

Dependents - Coverage for dependents will end on the earlier of:

- a) the Insured's termination date; or
- b) any premium due date, if full payment for the dependent's coverage is not made within 31 days following the premium due date; or
- c) the date the dependent is no longer eligible unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid.

Coverage will continue for any child who reaches the age limit and is both:

- a) totally incapable of self-sustaining employment due to a physical or intellectual disability; and
- b) chiefly dependent on the Insured for financial support and maintenance.

The Insured must give us proof of the child's incapacity and dependency within 31 days of the child reaching the age limit. We may require proof again from time to time but not more often than once a year after the 2 years that follow the child reaching the age limit.

In no case will coverage end later than the Insured's.

Termination will not affect a claim for benefits for covered events that occur while the person is covered by the policy.

EXTENSION OF BENEFITS

If coverage under the policy ends while the Covered Person is hospital confined or totally disabled due to Injury or Sickness, we will pay benefits for covered events occurring after the date coverage under the policy ends as long as they meet the following requirements:

- a) the covered event must be rendered due to the same Injury or Sickness causing the Covered Person to be hospital confined or totally disabled on the date coverage ends; and
- b) the covered event must occur within 90 days after the date the Covered Person's coverage under the policy ends; and
- c) coverage must not have ended as a result of the Covered Person's or, in the case of a dependent child, the child's parents voluntary termination of the coverage.

This extension of benefits terminates at the end of the 90-day period specified above.

As used in this section, "totally disabled" means:

- a) with respect to a Covered Person who would otherwise be employed, the complete inability to perform all of the substantial and material duties of such person's occupation; and

- b) with respect to a Covered Person who is not otherwise gainfully employed, confinement as an Inpatient in a Hospital.

DESCRIPTION OF BENEFITS

The following provisions describe the benefits we will pay for covered events. We will pay benefits for a covered event only once, even if the event could be included under more than one benefit description, unless otherwise indicated.

Hospital Confinement Daily Income Benefit

We will pay the applicable daily benefit amount shown on the Schedule of Benefits for each day a Covered Person is confined as an Inpatient in a Hospital if:

- a) the Hospital confinement is Medically Necessary; and
- b) the Covered Person is under a Doctor's care; and
- c) the Hospital confinement begins while the Covered Person is covered under the policy.

Payment of the applicable daily benefit will start on the first day of Hospital confinement and will continue for a period not to exceed the maximum benefit, as shown on the Schedule of Benefits.

Hospital Admission Benefit

We will pay the applicable daily benefit amount shown on the Schedule of Benefits for the first day a Covered Person is admitted to a Hospital as an Inpatient if:

- a) the Hospital admission is Medically Necessary; and
- b) the Covered Person is under a Doctor's care; and
- c) the Hospital admission occurs while the Covered Person is covered under the policy.

Daily benefits for Hospital admissions will be paid up to the applicable maximum benefit, as shown on the Schedule of Benefits. This benefit is payable in addition to any other benefit payable under the policy.

Additional Definitions - Wherever used in this benefit:

"Hospital admission" means each separate time a Covered Person is admitted to a Hospital as an Inpatient; except that if a Covered Person is admitted to a Hospital within 90 days after being discharged from a preceding Hospital admission for the same or a related cause, the second admission will be considered a part of the first Hospital admission.

General Anesthesia for Dental Care Benefit

We will pay, subject to the same terms and conditions as a Sickness covered under the policy, the applicable benefit amount shown on the Schedule of Benefits for any covered service rendered to a Covered Person in connection with the administration of general anesthesia (including, if applicable, the medical care facility charge), as described below.

Coverage will only apply to a Covered Person who:

- a) is 5 years of age or under; or
- b) is severely disabled; or

- c) has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

This benefit does not cover the dental care for which the anesthesia is required. In addition, this benefit does not apply to any dental care rendered for temporomandibular joint disorders.

CONTINUATION OF COVERAGE

Coverage for covered events that occur as a result of Injury or Sickness may be continued as described below. Medical information regarding the condition of a person's health is not required for this continued coverage.

Eligibility:

Insured - Insureds may elect to continue coverage for themselves and their covered dependents. Coverage may be continued for 18 months if one of the following events occurs:

- a) an Insured's employment is terminated for any reason other than gross misconduct; or
- b) a reduction in an Insured's hours results in the loss of such coverage.

Disabled Insured - Insureds who are determined to be disabled under the Social Security Act within 60 days of the date they become eligible for continuation under this provision, may continue coverage for themselves and their covered dependents for up to 29 months.

Dependents - A covered dependent may elect to continue coverage for a period of 36 months if one of the following events occurs:

- a) the death of the Insured;
- b) the divorce or legal separation of the Insured and dependent spouse;
- c) the Insured becomes entitled to Medicare benefits;
- d) a dependent child is no longer a dependent child for the purposes of the plan.

Coverage:

If a Covered Person exercises this option, coverage will be identical in scope to the coverage provided in the policy.

Premiums:

The Covered Person will pay premiums directly to the Contract Holder with the option of paying in monthly installments. The premiums will not exceed 102 percent of the applicable premium for such period.

Notice Requirements:

The Contract Holder must notify us in writing within 31 days after the date:

- a) the Insured dies; or
- b) the Insured's employment is terminated or the Insured's hours are reduced; or
- c) the Insured becomes entitled to Medicare benefits.

Each covered dependent who wishes to continue coverage must notify us in writing within 60 days after the date:

- a) of divorce or legal separation from the Insured; or
- b) a dependent child is no longer a dependent child for the purposes of the plan.

Covered Persons who wish to continue coverage must notify us in writing within 60 days after the date they receive notice of their right to continue coverage.

Termination:

Covered Persons who exercise this option will not have their coverage interrupted or canceled or otherwise terminated until the date on which:

- a) they fail to make a premium payment in the time required to make that payment; or
- b) they become covered under another group health plan, without limitation as to any pre-existing condition that affects coverage; or
- c) they become entitled to Medicare benefits; or
- d) the required period for continued coverage ends; or
- e) the policy is terminated.

EXCLUSIONS

No benefits will be paid for loss caused by or resulting from:

- a) intentionally self-inflicted injuries, suicide or any attempt thereat while sane or insane;
- b) declared or undeclared war or any act thereof;
- c) the Covered Person's commission of a felony.

In addition to the above exclusions, no benefits will be paid for:

- a) dental care, treatment or supplies other than covered events rendered in connection with the care and treatment of sound, natural teeth and gums required on account of Injury to the Covered Person resulting from an Accident that happens while covered under the policy, and rendered within 6 months of the Accident. This exclusion does not apply to the coverage provided under the General Anesthesia for Dental Care Benefit;
- b) care, treatment or supplies rendered in connection with cosmetic surgery, except covered events rendered in connection with cosmetic surgery the Covered Person needs for breast reconstruction following a mastectomy or as a result of an Accident that happens while covered under the policy. Cosmetic surgery for an accidental Injury must be performed within 90 days of the Accident causing the Injury and while such person's coverage is in force;
- c) care, treatment or supplies rendered to a Covered Person while outside the United States of America;
- d) care, treatment or supplies rendered by a member of the Covered Person's immediate family or provided by the Contract Holder.

PREMIUMS

Premiums are shown on the Schedule of Benefits. Premium must be paid to us on or before the premium due

date and not more than 31 days after the effective date of an eligible person's coverage. A person's coverage will not be affected by the Contract Holder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first Policy Anniversary Date, with 31 days' advance notice in writing to the Contract Holder.

Grace Period: The Contract Holder has a 31-day grace period after each ensuing premium due date once the first premium has been paid. If a subsequent premium is not paid by the end of the grace period, coverage will end as of the premium due date. If this happens, the Contract Holder will still owe us all premiums then due, including any premium due for the grace period or for any part of the grace period.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to us within 30 days after a loss occurs, or as soon as reasonably possible. Notice should include information that identifies the claimant and the policy.

Claim Forms: When we receive notice of claim that does not contain all necessary information or is not on an appropriate claim form, we will send forms for filing proof of loss to the claimant along with a request for any missing information. If these forms are not sent within 15 days after receiving notice of claim, the claimant will meet the proof of loss requirements if we are given, within 90 days, written proof of the nature and extent of the loss.

Proof of Loss: Written proof of loss must be given to us within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to us within 1 year after it is due, unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid immediately upon our receipt of proper written proof of such loss.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any benefits due and unpaid at the Insured's death will be paid to the Insured's estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the claim is pending.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 5 years from the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

Entire Contract; Changes: The policy (including the application, endorsements and attached papers) is the entire contract. In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of the policy, all statements made by the Contract Holder will be considered representations and not warranties. No written statement made by the Contract Holder will be used in any contest unless a copy of the statement is furnished to the Contract Holder. The enrollments of persons eligible for coverage (if any), are not a part of the policy; we may not use any statement contained in them to contest the policy or deny a claim. No change in the policy is valid unless it has been approved by one of our executive officers. This approval must be attached to or endorsed on the policy. No agent may change the policy or waive any provision.

Incontestability: The validity of the policy will not be contested except for nonpayment of premiums. No statement made by the Contract Holder or any Covered Person, except a fraudulent one, will be used to contest a claim under the policy. We may only contest coverage if the misstatement is made in a written instrument signed by the Contract Holder or the Covered Person and a copy is given to the Contract Holder or Covered Person.

Addition of Employees: Eligible new employees, and their dependents, will be added to the group originally covered, subject to the terms and conditions of the policy.

Conformity With State Law: If any part of the policy conflicts with the law of the state of delivery on the date the policy goes into effect, the policy is amended to meet the minimum requirements of such law.

Records Maintained; Examination and Audit: The Contract Holder or its agent will keep records showing the essential facts of each person's coverage. We may examine these records at any time that the policy is in force, within 3 years after the policy expires, and later if claims are still pending.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Termination of Policy: The Contract Holder may terminate the policy at any time on or after the first anniversary of the policy's effective date, by sending us written notice. The policy will be terminated on the date that we receive the notice or later if specified in the notice. We may terminate the policy at any time on or after the first anniversary of its effective date, by sending the Contract Holder at least 31 days' prior written notice to its most recent address in our records. We will return pro-rata the unearned portion of the premiums, if any, that were paid. Termination will be without prejudice to a claim for covered events that occurred while the policy was in force.

Certificate for the Insured: We will issue to the Contract Holder, for delivery to Insureds, a certificate of insurance containing the principal terms of the policy.