# Group Benefits

**Lakeview Community Schools**

**Critical Illness**

LEA, LESP and Part-time employees

CERTIFICATE OF
GROUP CRITICAL ILLNESS INSURANCE

**Union Security Insurance Company** certifies that the insurance stated in this Certificate became effective on the Effective Date shown in your Statement of Coverage form. In the event of a discrepancy between the certificate and the *policy* provisions, then the *policy* provisions will control. The *policy* is a legal contract between Union Security Insurance Company and the *policyholder*.

Union Security Insurance Company is domiciled in the State of Kansas.

| | |
|---|---|
| Policyholder: | Lakeview Community Schools |
| Group Policy Number: | 5460318 |
| Effective Date: | See Statement of Coverage form |
| Type of Insurance: | Group *Critical Illness Insurance*<br>Group *Critical Illness Insurance* for Dependents |

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, previously issued to you.

Tammy L. Schultz

President and
Chief Executive Officer

**Union Security Insurance Company** 2323 Grand Boulevard Kansas City Missouri 64108-2670

## SCHEDULE

**Eligible Classes:**

For employee insurance

Class I: Each *full-time* Lakewood Educational Association or Lakeview Educational Support Personnel employee of the *policyholder* or an *associated company*,

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

Class II: Each *part-time* employee hired prior to October 1, 2011 of the *policyholder* or an *associated company*,

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

For dependent insurance - Each *eligible dependent* of a person eligible and insured for employee insurance.

**Associated Companies:** None

**Service Requirement:**

Each *full-time* support staff in an *eligible class* – 40 day(s)
Each *part-time* employee in an *eligible class* – 40 day(s)

**Entry Date:** An eligible person will become insured on the day all eligibility requirements are met.

**Critical Illness Insurance**

At the time of enrollment, you may be eligible to select an amount of *critical illness insurance*. We will pay benefits corresponding to the elections you made as shown below.

You may change your or your *covered dependent's* amount of *critical illness insurance* according to the Plan Changes provision below.

Any limitation applies separately to you and each *covered dependent*.

Please see the Critical Illness Insurance provisions for a complete description of benefits, limitations and exclusions.

**Schedule Amount**

1. If you have not reached age 70, you may choose an amount of *critical illness insurance* equal to any multiple of $5,000 up to a maximum of $50,000.

2. If you are age 70 or more, your amount of insurance will be limited to 50% of the amount that you could have otherwise elected in 1 above. The amount will be rounded to the next higher multiple of $1,000, if not already an exact multiple.

Your amount of *critical illness insurance* may be limited by the Proof of Good Health provision. Any reduction based on age will apply to the amount of insurance in force, taking into account the Proof of Good Health provision.

**Age Reduction**

If you were insured before age 70, your amount of *critical illness insurance* will reduce by 50% when you reach age 70. This reduction will take effect on the policy anniversary occurring on or after your 70th birthday. Your

amount of insurance will be rounded to the next higher multiple of $1,000, if not already an exact multiple. No further increases to your benefit amount will be allowed after the age reduction has been applied. Any reduction will be subject to the other provisions of the *policy*.

**Maximum Schedule Amount Without Proof of Good Health:** None; *proof of good health* is required for all amounts

*Proof of good health* is required for *timely applicants* for any amount of insurance in excess of the amount shown above. All amounts of insurance are subject to the Pre-Existing Conditions provision.

**Schedule Amount for Dependents**

1. You may choose an amount of dependent *critical illness insurance* for your *covered dependent* spouse equal to any multiple of $2,500 subject to a maximum of $25,000.

2. You may choose an amount of dependent *critical illness insurance* for each *covered dependent* child of $2,500 or $5,000.

The amount of insurance for a dependent will not be more than 50% of your amount of insurance. This amount will be reduced if it exceeds 50% of your amount following an age reduction. Any reduction will take effect on the policy anniversary occurring on or after the change.

The amount of dependent *critical illness insurance* may be limited by the Proof of Good Health provision.

**Dependent Maximum Schedule Amount Without Proof of Good Health:**

| | |
|---|---|
| Spouse: | $0 |
| Child: | $0 |

*Proof of good health* is required for all amounts of insurance. All amounts of insurance are subject to the Pre-Existing Conditions provision.

**Benefits for Covered Critical Illnesses**

Benefits for a *covered person* are payable under this *policy* for only the *critical illnesses* listed below.

Please refer to the Critical Illness Insurance provisions for further explanation.

| **Critical Illness** | **First Diagnosis Benefit (Percentage of Schedule Amount)** | **Recurrence Benefit (Percentage of Schedule Amount)** |
|---|---|---|
| Heart Attack | 100% | 100% |
| Major Organ Failure | 100% | 100% |
| End-stage Kidney Disease | 100% | 100% |
| Stroke | 100% | 100% |
| Coronary Bypass Surgery | 25% | 25% |
| Occupational Infectious Disease | 100% | N/A |
| Benign Brain Tumor | 100% | N/A |
| Coma | 100% | N/A |
| Paralysis | 100% | N/A |
| Blindness | 100% | N/A |
| Loss of Speech | 100% | N/A |
| Complete Loss of Hearing | 100% | N/A |

**Cancer:**

| | | |
|---|---|---|
| Invasive Cancer | 100% | N/A |
| Cancer in Situ | 25% | N/A |
| Skin Cancer | 5% | N/A |

**Wellness Screening Benefit:**

| | |
|---|---|
| Benefit Amount: | $50 |

**Plan Changes**

**For Changes at Annual Enrollment**

You may change your plan of insurance only during the annual enrollment period agreed upon by the *policyholder* and us, unless you have a change in family status. You must submit *proof of good health* for any increase. The amount of any increase, with or without *proof of good health*, is subject to the Pre-Existing Conditions provision. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage. Any reductions based on age will apply to any increase.

The effective date of any change made during the annual enrollment period will be the later of the policy anniversary or the first of the month occurring on or after the date of our correspondence notifying you of our approval of a *covered person's proof of good health*, if required. Please see Exception to Effective Date if you are not at *active work* on the day the change in insurance would otherwise take effect, or if that day is not a regular work day. Please see Exception to Dependent Effective Date if your *covered dependent* is in a hospital or similar facility on the day the change in insurance would otherwise take effect.

**Change in Family Status**

You may apply for insurance for yourself or your *eligible dependent* or change your plan of insurance, within 31 days of a change in family status. A "change in family status" means your marriage or divorce, the birth or adoption of your child, the death of your spouse or child, the requirement of a court or administrative order to include coverage for your child, the termination of employment of your spouse, or any other event specified in the *policyholder's* IRC Section 125 plan, if any. Following a change in family status, you must submit *proof of good health* when applying for insurance, or increasing existing insurance for any *covered person*. However, if dependent insurance is being applied for within 31 days after your dependent first becomes an eligible dependent, *proof of good health* will only be required for any amount in excess of the Dependent Maximum Schedule Amount Without Proof of Good Health. Any amount or increase in insurance is subject to the Pre-Existing Conditions provision. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

If you are first applying for insurance for yourself or for your *eligible dependent* within 31 days after a change in family status, insurance will take effect on the first of the month occurring on or after the later of the date of the request or the date of our correspondence notifying you of our approval of your or your *eligible dependent's proof of good health*, if required.

If you are changing your existing plan of insurance, the effective date of any change due to a change in family status will be the first of the month occurring on or after the later of the date of the request or the date of our correspondence notifying you of our approval of your or your *eligible dependent's proof of good health*, if required.

Please see Exception to Effective Date if you are not at *active work* on the day the change in insurance would otherwise take effect, or if that day is not a regular work day. Please see Exception to Dependent Effective Date if your *covered dependent* is in a hospital or similar facility on the day the change in insurance would otherwise take effect.

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## GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns “we”, “us”, “our”, “you”, and “your” are not *italicized*.

*Active work* means the expenditure of time and energy for the *policyholder* or an *associated company* at your usual place of business on a *full-time* or *part-time* basis.

*Associated company* means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

*Contributory* means you pay part or all of the premium.

*Covered dependent* means an *eligible dependent* who is insured under the *policy*.

*Covered person* means an eligible employee or member of the *policyholder* or *associated company* who has become insured for a coverage. It also includes any *covered dependent*.

*Doctor* means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. Also, a person whom we are required to recognize as a *doctor* by the laws or regulations of the governing jurisdiction, or a person who is legally licensed to practice psychiatry, psychology or psychotherapy and whose primary work activities involve the care of patients, is a *doctor*. However, neither you nor a *family member* will be considered a *doctor*.

*Eligible class* means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

*Family member* means a person who is a parent, spouse, child, sibling, domestic partner, grandparent or grandchild of the *covered person*.

*Full-time* means working at least 20 hours per week, unless indicated otherwise in the *policy*.

*Home office* means our office in Kansas City, Missouri.

*Noncontributory* means the *policyholder* pays the premium.

*Part-time* means working at least 10 hours per week, unless indicated otherwise in the *policy*.

*Policy* means all:

- policy provisions;
- certificate(s) of group insurance;
- amendments;
- endorsements; and
- the *policyholder’s* application attached to the *policy*;

issued by us to the *policyholder* that describes the benefits for which you may be eligible.

*Policyholder* means the entity to whom the *policy* is issued.

*Proof of good health* means evidence acceptable to us of the good health of a person.

We, us, and our mean Union Security Insurance Company.

You and your mean an eligible employee or member of the *policyholder* or *associated company* who has become insured for a coverage.

## DEFINITIONS FOR CRITICAL ILLNESS INSURANCE

*Applicable percentage* means the percentage of the *benefit amount* that is payable for a *critical illness* as listed in the Schedule.

*Benefit amount* means the amount of insurance specified in the Schedule for which a *covered person* is insured.

*Benefit year* means a calendar year beginning on January 1 of any year and ending on December 31 of that year.

*Benign brain tumor* means a *covered person* has been initially *diagnosed* with a meningioma, lipoma or glioma arising from the brain or its meninges and is:

- confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
- resulting in persistent neurological deficits including but not limited to: loss of vision, loss of hearing or balance disruption.

Other conditions, including the following, are not considered a benign brain tumor:

- hematomas, cysts or granulomas; or
- intracranial malformations of the arteries or veins; or
- tumors in the pituitary gland, spine or cranial nerves, including pituitary adenoma, acoustic neuroma or craniopharyngioma.

In order for a benefit to be paid, the initial *diagnosis* of any benign brain tumor must occur while insured under the *policy*.

*Blindness* means that while insured under the *policy*, a *covered person* has been initially *diagnosed* with an irreversible reduction in sight, lasting at least 180 days, that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together. Benefits for blindness are not payable if the condition is a consequence of another condition for which another *critical illness* benefit has been paid.

*Cancer in situ* means that while insured under the *policy*, a *covered person* has been *diagnosed* with a cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Cancer in situ includes, but is not limited to:

- Early prostate cancer *diagnosed* as T1N0M0 or equivalent staging; and
- Melanoma not invading the dermis.

Cancer in situ does not include:

- Other skin malignancies, such as squamous cell or basal cell cancer; or
- Pre-malignant lesions (such as intraepithelial neoplasia); or
- Benign tumors or polyps; or
- *Invasive cancer*.

Cancer in situ must be supported by a pathological *diagnosis* or a clinical *diagnosis* if a pathological *diagnosis* is not possible.

*Cerebral vascular disease* means subarachnoid hemorrhage, intracerebral hemorrhage, brain embolism, brain thrombosis, occlusion and stenosis of precerebral arteries or occlusion of cerebral arteries.

*Coma* means that while insured under the *policy*, a *covered person* has been *diagnosed* with a condition from which a *covered person* cannot be aroused and which requires an external life support system, both of which have persisted continuously for at least 168 hours. A medically induced coma is excluded.

*Complete loss of hearing* means that a *covered person* has been initially *diagnosed* with a condition that results in the total and irreversible loss of hearing in both ears to a point that a *covered person* is unable to hear sounds at or below 70 decibels. The *diagnosis* must be confirmed using audiometric testing.

Complete loss of hearing does not include loss of hearing that can be corrected to above 70 decibels by the use of any hearing aid or device. Benefits for complete loss of hearing are not payable if the condition is a consequence of another condition for which another *critical illness* benefit has been paid.

In order for a benefit to be paid, the initial *diagnosis* of complete loss of hearing must occur while insured under the *policy*.

*Coronary artery disease* means acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the coronary arteries or coronary atherosclerosis due to plaque.

*Coronary bypass surgery* means that while insured under the *policy*, a *covered person* has been *diagnosed* with *coronary artery disease* requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon. Other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures are excluded.

*Critical illness or critical illnesses* means one of the following illnesses, *diagnosed* after your coverage effective date and while you are insured under the *policy*, and does not include any other illness, disease or health related event: *invasive cancer, cancer in situ, skin cancer, blindness, loss of speech, complete loss of hearing, benign brain tumor, paralysis* (other than *stroke*), *coma, heart attack, major organ failure, end-stage kidney disease, coronary bypass surgery, occupational infectious disease,* and *stroke.*

*Critical illness insurance* means the group critical illness insurance under the *policy* issued by us to the *policyholder*.

*Diagnosed, diagnosis* or *diagnoses* means an evaluation of a *covered person's* medical condition that is performed by a *doctor* whose specialty is appropriate for the condition being evaluated, and who is board certified in that specialty in accordance with the American Board of Medical Specialties criteria. The evaluation must include conclusions that are definite and supported by presence of symptoms, clinical signs on physical examination, and test results consistent with the most current medically accepted diagnostic standards according to *nationally recognized authorities*. A *diagnosis* must be based on conditions, clinical signs on examination, or test results that have changed substantially since becoming insured under the *policy*. In addition, the evaluation must meet one or more of the following criteria depending on the condition that is being evaluated:

- if cognitive function is being evaluated, the conclusions must be confirmed with neuropsychological testing conducted by a clinical psychologist at the doctorate level certified through the American Board of Professional Psychology in the area of clinical neuropsychology;
- if pulmonary function is being evaluated, the conclusion must be supported by testing performed in accordance with the American Thoracic Society criteria; and
- if the condition is evaluated using the results of exercise testing, that testing must be performed in accordance with the American College of Sports Medicine or American Heart Association standards.

*End-stage kidney disease* means that while insured under the *policy*, a *covered person* has been *diagnosed* with a renal disease that has resulted in either:

- the chronic and irreversible failure of both kidneys to function and which requires regular dialysis for a minimum of 90 days; or
- the need for a kidney transplant.

In the event a kidney is transplanted at the same time as other organs, only one benefit is payable.

*Heart attack* means that while insured under the *policy*, a *covered person* has been *diagnosed* with *coronary artery disease* that results in a current and new acute myocardial infarction due to blockage of one or more coronary arteries causing death of a portion of the heart muscle with loss of heart function. *Diagnosis* of the new myocardial infarction must be based on new changes consistent with an evolving infarction on electrocardiogram (EKG) and concurrent with serial measurement of cardiac biomarkers of a pattern and level of enzymes confirming an acute infarction. Old, established or silent myocardial infarctions are excluded.

*Injury* means unintentional physical damage or harm caused directly by an accident occurring while insured under the *policy* and not due to sickness, disease or any other causes.

*Invasive cancer* means that while insured under the *policy*, a *covered person* has been *diagnosed* with a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue, and which is not specifically hereafter excluded. Leukemias and lymphomas are considered invasive cancer.

The following are not considered invasive cancer:

- pre-malignant lesions (such as intraepithelial neoplasia);
- benign tumors or polyps;
- early prostate cancer *diagnosed* as T1N0M0 or equivalent staging;
- *cancer in situ*;
- any *skin cancer* (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic); and
- any non-malignant, non-invasive cancer or dysplasia of all grades.

Invasive cancer must be supported by a pathological *diagnosis* or a clinical *diagnosis* if pathological *diagnosis* is not possible.

*Loss of speech* means a *covered person* is initially *diagnosed* with total, permanent and irreversible loss of the ability to speak. The loss must be:

- as a result of *injury* or sickness affecting the speech organs; and
- have continued without interruption for a period of at least six (6) consecutive months.

Loss of speech does not include any loss that could be restored, totally or partially, by use of a device or implant. Benefits for loss of speech are not payable if the condition is a consequence of another condition for which another *critical illness* benefit has been paid.

In order for a benefit to be paid, the initial *diagnosis* of loss of speech must occur while insured under the *policy*.

*Major organ failure* means that while insured under the *policy*, a *covered person* is *diagnosed* with any end-stage disease as specified by the most current edition of the International Classification of Diseases (ICD) of the heart, liver, lung, small intestine, pancreas or bone marrow that has resulted in the chronic and irreversible failure of the organ to function and which requires the need for a transplant. In order for major organ failure resulting from an end-stage disease to be covered under this *policy*, the *covered person* must be registered with the United Network of Organ Sharing (UNOS) or be registered for matching a donor on the National Marrow Donor Program (NMDP). If multiple organs are to be replaced at the same time only one benefit is payable.

*Nationally recognized authorities* means the American Medical Association (AMA) Council on Scientific Affairs, the AMA Diagnostic and Therapeutic Technology Assessment Project, the AMA Board of Medical Specialties, the American College of Physicians and Surgeons, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Office of Technology Assessment, the National Institutes of Health, the Health Care Finance Administration, the Agency for Health Care Policy and Research, the Department of Health and Human Services, the National Cancer Institute, and any additional organizations we choose which attain similar status.

*Occupational infectious disease* means that a *covered person* is initially *diagnosed* while insured under the *policy* with Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C and/or D resulting from accidental exposure to HIV or Hepatitis B, C and/or D by contaminated body fluids during the course of performing a *covered person's* regular occupation for which remuneration is earned. To prove occupational exposure, all of the following must be submitted:

- Documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulations or standard guidelines that apply to the occupation;
- A negative antibody for HIV or Hepatitis B, C and/or D test, performed by a state certified and licensed laboratory within five days of exposure; and
- A positive antibody for HIV or Hepatitis B, C and/or D test, taken in the 90 to 180 days following the exposure.

Occupational infectious disease does not include HIV or Hepatitis B, C and/or D that occurs as a result of IV drug use, sexual transmission or is determined not to be accidental.

In order for a benefit to be paid, the initial *diagnosis* of occupational infectious disease must occur while insured under the *policy*.

*Paralysis* means that while insured under the *policy*, a *covered person* has been *diagnosed* with total and irreversible loss of use of two or more limbs due to *injury* and that is continuously present for a period of at least 180 days. Paralysis shall not include any impairment caused by a *stroke* or other sickness.

*Port* means to convert to group portability coverage.

*Skin cancer* means that while insured under the *policy*, a *covered person* has been *diagnosed* with basal cell cancer or squamous cell cancer of the skin.

*Stroke* means that while insured under the *policy*, a *covered person* has been *diagnosed* with *cerebral vascular disease* resulting in a brain tissue infarction. The basis of the *diagnosis* must include imaging documentation of new brain tissue infarction in association with acute onset of symptoms consistent with central nervous system neurological damage.

For the purposes of this *policy*, stroke does not include:

- Transient Ischemic Attacks (TIAs);
- Transient Global Amnesia (TGA); or

- External trauma causing injury to the brain.

*Timely applicant* means a person whose application for insurance is made no later than 90 days after becoming eligible for insurance under the *policy*.

*Treatment* means any medical service, procedure, consultation, advice, tests, observation, supplies, equipment, x-rays, or surgery, including the prescription of drugs or use of prescription drugs or insulin.

## SUMMARY OF GROUP CRITICAL ILLNESS INSURANCE

This summary is intended to help understand the group insurance *policy*. It does not change any of its provisions.

**Critical Illness Insurance**

You may be eligible to elect certain amounts and the coverage in force for a *covered person* will depend on the elections made.

The *policy* pays a fixed benefit when a *covered person* is *diagnosed* with a covered *critical illness*.

The *critical illness* must be *diagnosed* after a *covered person's* effective date and while he or she is insured under this *policy*. Benefits are subject to the limitations and exclusions described in this *policy*.

The *policy* explains the situations in which a *covered person* will receive limited or no benefits. In addition, pre-existing exclusions may apply to some situations.

The *policy* includes a portability provision. If a *covered person's critical illness insurance* ends under certain circumstances, it may be possible to *port* the *covered person's critical illness insurance*.

Premiums must continue to be paid, either under the *policy* or under the group portability coverage, if eligible, for benefits to be paid.

**IMPORTANT: The benefits of this *critical illness insurance* are provided under a limited *policy*. This is NOT medical insurance, a Medicare Supplement plan or a high deductible health plan.**

**Please read the following pages carefully.**

## ELIGIBILITY AND TERMINATION PROVISIONS FOR CRITICAL ILLNESS INSURANCE

### Eligible Persons

To be eligible for insurance, a person must:

- be a member of an *eligible class*; and
- complete any Service Requirement shown in the Schedule by continuous service with the employer, the *policyholder*, or an *associated company*; and
- give us *proof of good health*, if required.

The Present Service Requirement applies to persons in an *eligible class* on the Effective Date of the *policy*. The Future Service Requirement applies to persons who become members of an *eligible class* after that.

### Effective Date for an Eligible Person

*Proof of good health* is required for any amount in excess of the Maximum Schedule Amount Without Proof of Good Health. Any *noncontributory* insurance will take effect on the Entry Date shown in the Schedule unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, any *noncontributory* insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your *proof of good health*.

For any *contributory* insurance, a person must apply for insurance on a form acceptable to us, and agree to pay part or all of the premium. Insurance will take effect on the following:

- If a person applies before becoming eligible, *proof of good health* is required for any amount in excess of the Maximum Schedule Amount Without Proof of Good Health. Insurance will take effect on the Entry Date shown in the Schedule in the *policy* unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your *proof of good health*.
- If the application is made on the date the person becomes eligible, or within 90 days after that, *proof of good health* is required for any amount in excess of the Maximum Schedule Amount Without Proof of Good Health. Insurance will take effect on the Entry Date occurring on or after the date of the application unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your *proof of good health*.
- If application is made more than 90 days after the day the person becomes eligible, or after insurance ended because the premium was not paid, *proof of good health* is required for all amounts of coverage and application must be made during an annual enrollment period. Insurance will take effect on the later of the policy anniversary occurring on or after the date of the application or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your *proof of good health*.

In no event will a person's insurance take effect before the *policyholder's* effective date.

### Exception to Effective Date

If an eligible person is not at *active work* on the day insurance would otherwise take effect, insurance will not take effect until the person returns to *active work*. If the day insurance would normally take effect is not a regular work day for a person, insurance will take effect on that day if the person is able to do his or her regular job.

**When a Person's Insurance Ends**

Your insurance will end on the date:

- the *policy* ends;
- the *policy* is changed to end the insurance for a person's *eligible class*;
- a person is no longer in an *eligible class*;
- a person stops *active work*; however, for a *covered person* who renews his or her contract with the *policyholder* for the next school year, the *policyholder* may consider insurance to continue even though the person stops *active work* during the summer recess;
- a required contribution was not paid; or
- all benefits paid or payable for you under this *policy* reach the maximum amount payable as described in the Schedule.

If your insurance ends, you may be eligible to *port* your insurance and continue your benefits. Please see the Portability provision.

**Re-entry**

If a person re-enters an Eligible Class within 12 months after insurance ends, the person will not have to complete the Service Requirement again. Any Pre-Existing Conditions provision will be applied as if insurance never ended if a person re-enters an Eligible Class immediately after the end of a family or medical leave of absence under the federal Family and Medical Leave Act or any similar state law. All other provisions of the *policy* will apply as if the person were newly eligible.

## DEPENDENT ELIGIBILITY AND TERMINATION PROVISIONS FOR CRITICAL ILLNESS INSURANCE

### Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- your children from live birth but less than age 26.

"Children" include the following:

- natural children;
- adopted children—a child will be considered adopted on the date of placement in your home;
- stepchildren and foster children, if they depend on you for support and maintenance;
- children, other than your natural or adopted children, for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance; and
- children you are required to cover pursuant to a court or administrative order.

An *eligible dependent* will not include any person who is a member of an *eligible class*. If you and your spouse are both members of an *eligible class*, one of you may request to be an *eligible dependent* of the other. An *eligible dependent* may not be covered by more than 1 *covered person*.

### Dependent Effective Date

*Proof of good health* is required for any amount in excess of the Dependent Maximum Schedule Amount Without Proof of Good Health. Any *noncontributory* dependent insurance will take effect on the Entry Date shown in the Schedule unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, any *noncontributory* dependent insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your dependent's *proof of good health*.

For any *contributory* dependent insurance, you must apply for dependent insurance on a form acceptable to us, and agree to pay part or all of the premium. Insurance will take effect on the following:

- If you apply before the dependent becomes eligible, *proof of good health* is required for any amount in excess of the Dependent Maximum Schedule Amount Without Proof of Good Health. Dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy* unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, dependent insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your dependent's *proof of good health.*
- If you apply on the date the dependent becomes eligible, or within 90 days after that, *proof of good health* is required for any amount in excess of the Dependent Maximum Schedule Amount Without Proof of Good Health. Dependent insurance will take effect on the Entry Date occurring on or after the date of your application unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, dependent insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your dependent's *proof of good health.*
- If you apply more than 90 days after the day the dependent becomes eligible, or after dependent insurance ended because the premium was not paid, *proof of good health* is required for all

amounts of coverage and application must be made during an annual enrollment period. Dependent insurance will take effect on the policy anniversary occurring on or after the date of application, or, if later, the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your dependent's *proof of good health*.

**Exception to Dependent Effective Date**

Dependent insurance will not take effect until your insurance for the same coverage under the *policy* takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect. Dependent insurance for a newborn dependent child, including an adopted newborn dependent child, will automatically take effect at birth. Insurance will continue for 31 days. If you want insurance to continue for a newborn beyond 31 days, you must notify us (if you do not already have dependent child insurance) and make the required premium payment within the 31-day period. If your newborn dependent child is *diagnosed* with a *critical illness* shown in the Schedule within this 31-day time period and prior to your election of coverage, the lowest dependent child benefit will be payable.

**When Dependent Insurance Ends**

A dependent's insurance will end on the date:

- the *policy* ends;
- the *policy* is changed to end dependent insurance;
- that dependent is no longer eligible;
- on the date your insurance for the same coverage under the *policy* ends; or
- on the date a required contribution for dependent insurance was not paid.
- all benefits paid or payable for you under this *policy* reach the maximum amount payable as described in the Schedule; or
- all benefits paid or payable for a *covered dependent* under this *policy* reach the maximum amount payable as described in the Schedule. *Critical Illness insurance* for *covered dependents* who have not reached the maximum amount payable will continue as long as all other *policy* provisions apply.

If your and your dependent insurance ends, you may be eligible to *port* your insurance and continue your benefits. Please see the Portability provision.

## SPECIAL INSURANCE CONTINUANCE PROVISIONS

### Continuance of Insurance

The *policyholder* may elect to continue your insurance and your dependent insurance, if any, on a premium-paying basis if you are unable to perform *active work* for a reason shown below. You must remain in other respects a member of the *eligible class*. The continuance cannot be more than the maximum continuance shown below but may be a lesser time period as elected by the *policyholder*. Continuance must be based on a uniform policy, and not individual selection.

The maximum continuance for *critical illness insurance* is the longest applicable period described below:

- 12 months* for *injury*, sickness, or pregnancy;
- 3 months* for temporary lay-off (only with the *policyholder's* expectation that you will resume *active work*), leave of absence (other than a family or medical leave of absence described below), or change to part-time; or
- the end of the period the *policyholder* is required to allow* for a family or medical leave of absence under:
    - the federal Family and Medical Leave Act; or
    - any similar state law.

*after the last day of *active work*.

Any leave of absence, including a family or medical leave of absence described above, must be approved in advance in writing by the *policyholder* if the insurance is to be continued.

### Dependent Continuance

As specified below, dependent *critical illness insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy*. Premiums are required for any coverage continued.

#### Physically or Mentally Handicapped Dependent Children

Dependent *critical illness insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical or mental handicap; and
- is chiefly dependent upon you for support and maintenance.

We must receive proof of the above within 120 days after the child attains the age limit and each year after that, beginning 2 years after the child attains the age limit. There will be no increase in premium for this continued coverage.

Dependent *critical illness insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.

### Federal Continuance

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a *covered person* may have the right to continue *critical illness insurance* coverage beyond the date insurance would otherwise terminate. You should contact the *policyholder* concerning your right to continue coverage.

## CRITICAL ILLNESS INSURANCE

### Insurance Provided

If a *covered person* is *diagnosed* with a *critical illness* while insured under the *policy*, we will pay the benefits shown in the Schedule. The *critical illness* must be *diagnosed* while the *covered person* is insured under this *policy* and is subject to the limitations and exclusions described in this *policy*.

Any benefits are subject to the provisions of the *policy*.

Any required premiums must continue to be paid, either under the *policy* or under the group portability coverage, if eligible, for benefits to be paid.

### Proof of Good Health

If you are eligible for more than the Maximum Schedule Amount Without Proof of Good Health or your *eligible dependent* is eligible for more than the Dependent Maximum Schedule Amount Without Proof of Good Health shown in the Schedule, you or your *eligible dependent* will be limited to that maximum until you give us *proof of good health* for yourself or your *eligible dependent*.

### Amount of Benefit

Each *critical illness* is included in the Schedule. For each *critical illness diagnosed*, we will pay the *applicable percentage* of the *benefit amount* shown in the Schedule.

If benefits for a particular *critical illness* have been paid, a *covered person* is not eligible for any additional benefits if the *covered person* is ever *diagnosed* with that *critical illness* again, except as described in the Recurrence Benefit provision.

If a *covered person* is *diagnosed* with more than one *critical illness* on the same date, we will pay only the benefit for the *critical illness* with the largest *applicable percentage*.

### Additional Occurrence Benefit

If we pay benefits for a particular *critical illness*, we will pay benefits for a different *critical illness* listed in the Schedule, if there are more than 6 consecutive months between *diagnoses*.

### Recurrence Benefit

We will pay a recurrence benefit, as shown in the Schedule, if:

- benefits have been paid under this *policy* because a *covered person* was *diagnosed* with a *critical illness*,
- a *covered person* is *diagnosed* with the same *critical illness* more than 12 consecutive months later, and
- the *covered person* has not received *treatment* for the same *critical illness* for 12 consecutive months after the *diagnosis* for the *critical illness*. For the purposes of this provision, we will not consider follow-up visits to a *doctor* or prescription medications other than cytotoxic medications (cancer chemotherapy) to be *treatment*.

Once the recurrence benefit has been paid, a *covered person* is not eligible for any additional benefits if the *covered person* is ever *diagnosed* with that *critical illness* again.

**Wellness Screening Benefit**

We will pay the Wellness Screening Benefit Amount shown in the Schedule if you provide proof satisfactory to us that a *covered person* had a wellness screening test performed while covered under the *policy*. This benefit is limited to the wellness screening tests listed below and is limited to one test per *benefit year* per person.

- cardiac exercise stress test
- fasting blood glucose test
- blood test for lipids including total cholesterol, LDL, HDL and triglycerides
- breast ultrasound or mammography
- CA15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- chest x-ray
- colonoscopy
- flexible sigmoidoscopy
- hemocult stool analysis
- pap smear
- PSA (blood test for prostate cancer)
- serum protein electrophoresis
- carotid doppler
- electrocardiogram
- echocardiogram.

This benefit will be paid as long as the *policy* is in force and the *covered person* remains insured under the *policy*. The benefit will be paid regardless of the results of the test. The wellness screening benefit is paid in addition to any other benefits payable under the *policy*. In order to receive this benefit, you must submit proof that the wellness screening test was performed by providing us with documentation from your *doctor*.

**Pre-Existing Conditions**

We will not pay benefits for claims resulting, directly or indirectly, from a pre-existing condition (defined below) unless a *covered person* is *diagnosed* with a *critical illness* after 12 consecutive months during which a *covered person* is continuously insured under the *critical illness insurance policy*.

A "pre-existing condition" means an *injury*, sickness, symptom or physical finding, or any related *injury*, sickness, symptom or physical finding, for which a *covered person*:

- consulted with or received advice from a licensed medical or dental practitioner; or

- received medical or dental care, *treatment*, or services, including taking drugs, medicine, insulin, or similar substances

during the 12 months that end on the day before a *covered person* became insured under the *critical illness insurance policy*.

**General Exclusions**

We will not pay benefits for a *covered person* if the *critical illness* is related to or resulting directly or indirectly from:

- Services or *treatment* not included in the Schedule
- Services or *treatment* for which a *covered person* is not charged, unless there is no charge because the facility is a United States government facility
- Services or *treatment* provided by a *family member*
- Any *critical illness* that is *diagnosed* outside of the United States
- Services or *treatment* rendered outside the United States
- Services or *treatment* provided primarily for cosmetic purposes
- *Treatment* or complications of *treatment* not related to a *critical illness*
- An autologous bone marrow transplant, one in which your own bone marrow is used
- Service in the armed forces or related auxiliaries such as the National Guard or Army Reserve of any country, combination of countries, or international organization at war, whether declared or not
- War or any act of war, whether declared or not
- Taking part in a riot or insurrection, or an act of riot or insurrection
- Committing or attempting to commit an assault or felony
- Incarceration in a penal institution of any kind
- Intentionally self-inflicted injury, while sane or insane
- Suicide or attempted suicide, while sane or insane

**Portability**

If all of your *critical illness insurance* ends for a reason other than you did not pay your share of the premium, you may be eligible to *port* your and your *covered dependent's* insurance currently in force. You must *port* your *critical illness insurance* in order to *port* your *covered dependent's critical illness insurance*. A *covered dependent* may not *port* his or her *critical illness insurance*. Your and your *covered dependent's* insurance under the group portability coverage will be a continuation of your and your *covered dependent's* insurance under this *policy* and all benefits, limitations and exclusions under this *policy* will continue to apply to your and your *covered dependent's* insurance under the group portability coverage.

You are not eligible to *port* if the *critical illness insurance* ends because you did not pay your share of the premium.

You must apply and pay the premium within 31 days after your coverage ends. No *proof of good health* is required.

If you or your *covered dependent* is *diagnosed* with a covered *critical illness* within 31 days after your *critical illness insurance* ends, but before you have applied to *port*, we will pay any benefits as if you had *ported*. However, you must pay any premium due. The insurance can be continued under the group portability coverage until the later of the day before your 70th birthday or 12 months from the date your coverage was *ported*. You may either *port* the plan of insurance that is currently in force, or you may *port* to a lower plan of insurance. You cannot *port* to a higher plan of insurance.

We will notify you of the amount of premium due, the frequency of premium payments and the premium due dates. If any premium is not paid when due, you will have a 31 day grace period. Insurance will end at the end of the grace period if you fail to make the required premium payment within that time. We will not change the premium rate more than once in any period of 6 consecutive months and we will give you 31 days advance written notice of any change in rates.

**Assignment**

Neither you nor your *covered dependent* can assign any of the *critical illness insurance* benefits.

## CLAIM PROVISIONS FOR CRITICAL ILLNESS INSURANCE

### Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss.

### To Whom Payable

We will pay all benefits to you. However, if medical evidence indicates that a legal guardian should be appointed, we will hold further benefits due until such time as a guardian of your estate is appointed and we will pay benefits to such guardian at that time.

If any amount remains unpaid when you die, we will pay benefits due to the first qualified surviving class of the following classes in this order:

- your lawful spouse;
- your living children, in equal share;
- your living parents, in equal shares; or
- your estate.

However, benefits paid on behalf of a *covered person* under the *policy* shall be paid to the Michigan Human Services Department when:

- the Michigan Human Services Department has paid or is paying benefits on behalf of a *covered person* under Michigan's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;
- payment for the services in question has been made by the Michigan Human Services Department to the Medicaid provider; and
- we are notified that a *covered person* receives benefits under the Medicaid program and that benefits must be paid directly to the Michigan Human Services Department.

If you are not the custodial parent of your *covered dependent* children, we will pay any claims submitted on behalf of your *covered dependent* children to the custodial parent of your *covered dependent children*.

Any amount we pay in good faith releases us from further liability for that amount.

### Filing a Claim

You must send us notice of the claim. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, to one of our regional group claims offices, or to one of our agents or administrators. We need enough information to identify you as a *covered person*.

Within 15 days after the date of your notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or to one of our regional group claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

The time limit for filing a claim is 90 days after the date of the loss, *treatment* or service.

### Proof of Loss

Written proof of loss must be furnished to our *home office*, to one of our regional group claims offices, or to one of our agents or administrators within 90 days after the occurrence or commencement of any covered loss.

In the case of claims for loss for which this *policy* provides any periodic payment contingent upon continuing loss, proof of loss must be furnished within 90 days after the termination of the period for which we are liable. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

You must provide us with all of the information we specify as necessary to determine proof of loss and decide our liability. This may include but is not limited to medical records, hospital records, pharmacy records, test results, therapy and office notes, mental health progress notes, medical exams and consultations, tax returns, business records, payroll and attendance records, billing records, invoices, receipts, police reports and investigative reports.

You must provide us with a written authorization allowing the sources of medical, vocational, occupational, financial, and governmental information to release documents to us which enables us to decide our liability. If you do not provide us with the items and authorization necessary to allow us to determine our liability, we will not pay benefits.

**Right to Examine or Interview**

We may ask a *covered person* to be examined as often as we require at any time we choose. We may require a *covered person* to be interviewed by our authorized representative. We will pay third party charges for any independent medical exam or interview which we require. If a *covered person* fails to attend or fully participate we will not pay benefits.

**Limit on Legal Action**

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the applicable statute of limitations has expired, but, in any case, not after 3 years from the date of loss.

**Review Procedure**

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 30 days after we receive your request or within 60 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the *policy*. We will also advise of further appeal rights, if any.

**Incontestability**

The validity of the *policy* cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the *policyholder* or a *covered person* will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the *covered person*.

No statement, except fraudulent misstatement, made by a *covered person* about insurability will be used to deny a claim for a loss incurred after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the *covered person's* effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

**Overpayment**

We have the right to recover any overpayments due to:

- fraud; or
- any administrative error we make in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

We will not recover more money than the amount we paid you. However, we reserve the right to recover any prior or current overpayment from a claim under the *policy*.

# HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL, DENTAL AND VISION INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to our HIPAA covered healthcare plans, including dental, vision, cancer only, hospital indemnity, and critical illness.

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## I. Our Commitment

Union Security Insurance Company, Union Security Life Insurance Company of New York, and the prepaid dental companies* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

The Health Insurance Portability and Accountability Act (HIPAA) provides guidelines and standards to follow when we use or disclose your Protected Health Information (PHI). This law also gives you, our customer, numerous rights regarding your ability to see, inspect, and copy your PHI. Because our commitment to privacy means complying with all privacy laws, we are providing you this notice outlining our privacy practices. The following information is intended to help you understand what we can and cannot do with your PHI and what your rights are under HIPAA.

## II. Our Use and Disclosure of Your PHI

HIPAA allows us to use and disclose your PHI for treatment, payment, and healthcare operations without asking your permission. For instance, we may disclose information to a healthcare provider to assist the provider in properly treating you or a dependent (Treatment). We may disclose certain information to the healthcare provider in order to properly pay a claim or to your employer in order to collect the correct premium amount (Payment). We may disclose your information in order to help us make the correct underwriting decision or to determine your eligibility (Operations).

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.

We can also make disclosures under the following circumstances without your permission:

- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;

- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, eligibility or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

**Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice,** including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

## III. Your Individual Rights

You have the following rights with regard to your Protected Health Information:

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in the past six years in which we or our business associates have disclosed your PHI for purposes <u>other</u> than treatment, payment, health care operations, or as authorized by you. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.
- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.

- **To Be Notified of a Breach:** You will be notified in the event that unsecured protected health information is compromised.
- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our web site or by electronic mail, you may request a paper copy.

## IV. Who to Contact for Questions and Complaints

If you want more information about our privacy practices, wish to exercise any of your rights with regard to your PHI, or have any questions about the information in this notice, please use the contact information below. If you believe we may have violated your privacy rights, or if you disagree with a decision that we made in connection with your PHI, you may file a complaint using the contact information below. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may locate the regional office nearest to you by visiting their web site, http://www.hhs.gov/ocr/. We fully support your right to the privacy of your PHI, and will not retaliate in any way if you choose to file a complaint.

Mailing Address: **Sun Life Financial**
Privacy Officer
P.O. Box 419052
Kansas City, MO 64141-6052
Telephone: 800.733.7879
Email: SLF_US_Privacy@sunlife.com
Web Site: www.sunlife.com/us

**For New York business:**

Mailing Address: **Union Security Life Insurance Company of New York**
Privacy Officer
Administered by:
**Sun Life Financial**
P.O. Box 419052
Kansas City, MO 64141-6052
Telephone: 888.901.6377
Email: SLF_US_Privacy@sunlife.com

## V. Organizations Covered by This Notice

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

## VI. Effective Date of This Notice: April 14, 2003.

Revised: October 21, 2016

*** In this notice, "we," "us," and "our" refer to Union Security Insurance Company, Union Security Life Insurance Company of New York and the following prepaid dental companies:** DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, Inc., UDC Dental California, Inc., UDC Ohio, Inc., United Dental Care of Arizona, Inc., United Dental Care of Colorado, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., United Dental Care of New Mexico, Inc., United Dental Care of Texas, Inc., United Dental Care of Utah, Inc., Union Security DentalCare of New Jersey, Inc.

Insurance products are underwritten by Union Security Insurance Company (USIC) (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) in all states except New York. Prepaid dental products are provided by USIC and are administered by SLOC, and are provided by prepaid dental companies affiliated with SLOC in certain states except New York. Prepaid dental companies are

Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, insurance products and prepaid dental products are underwritten or provided by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

## SUMMARY PLAN DESCRIPTION

This Summary Plan Description is issued to you in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). Included within this document is your Certificate of Insurance, issued by Union Security Insurance Company in compliance with state law. Your Summary Plan Description does not replace or modify the Master Policy issued by Union Security Insurance Company in any way. The Master Policy is the contract which sets forth the terms and conditions of the benefits the Plan Sponsor chose to provide in its welfare benefit plan. The Master Policy may be amended at any time by agreement between the Plan Sponsor and Union Security Insurance Company. The Master Policy may be terminated at any time by the Plan Sponsor or may be terminated by Union Security Insurance Company for non-payment of premium or for failure to meet the Master Policy's minimum participation requirements. The Plan Administrator has the obligation to prepare, issue, amend and file the Summary Plan Description (SPD) and is solely responsible for its contents.

## GENERAL ADMINISTRATIVE PROVISIONS

**Name of the Plan:**

Lakeview Community Schools

**Plan Sponsor:**

Lakeview Community Schools
123 5th St
Lakeview, MI 48850
989.352.6226

**Employer I.D. Number:**

38-6025862

**Type of Plan:**

An employee welfare plan providing benefits for:

Critical Illness Insurance
Critical Illness Insurance for Dependents

**Plan Number:**

PN501 unless another number is assigned by the employer, the Plan Administrator, or on any Form 5500 filed for the Plan.

**Effective Date:**

The plan, as described in this SPD, became effective on January 1, 2017.

Any italicized terms are defined in the certificate, which is hereby incorporated by reference.

**Who Is Eligible:**

Class I: Each full-time Lakewood Educational Association or Lakeview Educational Support Personnel employee of the *policyholder* or an *associated company*,

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

Class II: Each part-time employee hired prior to October 1, 2011 of the *policyholder* or an *associated company*,

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

For dependent insurance - Each *eligible dependent* of a person eligible and insured for employee insurance.

**Service Requirement:**

Each full-time support staff in an *eligible class* – 40 day(s)

Each part-time employee in an *eligible class* – 40 day(s)

**Entry Date:** An eligible person will become insured on the day all eligibility requirements are met.

Full-time means working at least 20 hours per week.

Part-time means working at least 10 hours per week.

The plan may also cover other persons not included above. Check with the plan administrator.

**Plan Administrator:**

Lakeview Community Schools
123 5th St
Lakeview, MI 48850
989.352.6226

**Type of Administration:**

This plan is insured by a contract with Union Security Insurance Company, 2323 Grand Boulevard, Kansas City, Missouri 64108-2670.

**Amendment or Termination of Plan:**

This plan may be amended or terminated at any time by the Plan Sponsor.

**Agent for Service of Legal Process:**

Lakeview Community Schools
123 5th St
Lakeview, MI 48850
989.352.6226

**Plan Records:**

The fiscal records for the plan are kept on a policy year basis ending on the last day of December each year.

**Cost of Benefits:**

The premiums for the Critical Illness Insurance plan for employees are paid for entirely by you.

The premiums for the Critical Illness Insurance for Dependents plan are paid for entirely by you.

**Your plan includes:**

Critical Illness Insurance
Critical Illness Insurance for Dependents

The benefits, limitations and exclusions are described in the Certificate which is found within this Description.

## STATEMENT OF ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

(i) Examine, without charge at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and, if required, a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(ii) Obtain, upon written request to the plan administrator, copies of all documents governing the plan, including insurance contracts and collective bargaining agreements, and, if required, copies of the latest annual report (Form 5500 Series) and the updated summary plan description. The administrator may make a reasonable charge for the copies.

(iii) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

(iv) Obtain, without charge, a copy of the plan’s procedures governing qualified medical child support order determinations.

(v) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate our plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for welfare benefits is denied in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court may decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

### Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group Critical Illness coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights.

The Plan Administrator is responsible for administering COBRA continuation coverage.

### COBRA Continuation Coverage

COBRA continuation coverage is a continuation of the Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

Your dependent spouse will become a qualified beneficiary if your dependent spouse loses coverage under the Plan because any of the following qualifying events happens:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct; or
4. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become divorced or legally separated; or
5. The child stops being eligible for coverage under the Plan as a "dependent child".

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the employee, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability Extension of 18-month Period of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator.

**Second Qualifying Event Extension of 18-month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your spouse and dependent children if you die or you get divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

**If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

**Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## CLAIMS PROCEDURE

The following procedures apply to the extent benefits under your employee benefit plan are insured under a contract issued by Union Security Insurance Company.

### PRESENTING A CLAIM

Contact your plan administrator, who will advise you of any forms which are required. These forms should be returned to the Plan Administrator after completion. This Administrator will review them, complete any information concerning eligibility and forward them to Union Security Insurance Company. Time limits for filing the claim and other requirements for notice and proof of loss may be found under the heading, "Filing A Claim".

### NOTIFICATION OF DECISION— CRITICAL ILLNESS

A decision will be made within 30 days after receipt by Union Security Insurance Company of a properly executed, complete proof of loss, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. Such an extension of time may not exceed 15 additional days. If the claim is denied in whole or in part, Union Security Insurance Company will provide written notice either directly to you or to the Plan Administrator for delivery to you. The written notice will contain:

1. The specific reason or reasons for the denial;
2. Specific reference to pertinent provisions of the policy upon which the decision is based;
3. A description of any additional material or information needed to perfect the claim and an explanation of why it is necessary; and
4. An explanation of the plan's claim review procedure.

### REVIEW PROCEDURE—CRITICAL ILLNESS

You are entitled to a full and fair review of denial of claim. You may make a request to the Plan Administrator or appropriate named fiduciary, if other than the Plan Administrator. The procedure is as follows:

1. The request for review must be in writing and made within 180 days of receipt of written notice of denial;
2. You may review, upon request and free of charge, copies of all documents, records, and other information relevant to the claim for benefits. You have the right to review copies of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making our decision to deny your claim. You have the right to request that we identify all medical experts whose advice was obtained on behalf of the plan;
3. You have the right to submit issues and comments in writing, along with additional documents, records, and other information relating to the claim;
4. If our decision is based on medical necessity or experimental treatment or similar exclusion or limit, you have the right to an explanation of the scientific or clinical judgement for the determination, which will be provided upon request and free of charge;
5. The Plan Administrator will forward the request to Union Security Insurance Company;
6. Union Security Insurance Company will make a decision upon review within 60 days after receipt of the request. The decision on review will be in writing, include the specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based and be furnished either directly to you or to the Plan Administrator for delivery to you.

**Union Security Insurance Company**
2323 Grand Boulevard
Kansas City, MO 64108

Policy 5460318
Participant 0
Booklet 11
1/7/2017