ACE American Insurance Company
436 Walnut Street
Philadelphia, PA 19106

Group Hospital Indemnity Certificate of Insurance

POLICYHOLDER:	Trustee of the ACE USA Accident & Health Insurance Trust on behalf of {ABC Company}
POLICY NUMBER:	HIP N0{XX-XXXXX}
POLICY ANNIVERSARY DATE:	{March 1}
PARTICIPATING ORGANIZATION:	{ABC Company}

The Policy takes effect at 12:00 a.m. (midnight) on the Policy Effective Date shown above. In return for payment of the required premiums, We will pay benefits according to the terms and conditions of coverage described in the Policy.

The Policy is governed by the laws of the state in which it is delivered.

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania

JOHN J. LUPICA, President

REBECCA L. COLLINS, Secretary

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This certificate provides limited benefits on a fixed indemnity basis. It does not constitute comprehensive health insurance coverage (often referred to as “major medical coverage”) and does not satisfy a person’s individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA). For more information about the ACA, please refer to www.HealthCare.gov.

PLEASE READ THE CERTIFICATE CAREFULLY.

SCHEDULE OF BENEFITS

CLASSES OF ELIGIBLE PERSONS:

A person may be insured only under one Class of Eligible Persons even though he or she may be eligible under more than one class. Also, a person may not be insured as a Dependent and an Insured at the same time.

Class 1 All full-time employees of the Participating Organization who are in Active Service and have selected the [$1,000 / $2,000 / $3,000 / $5,000] Plan.

[Class 2 All part-time employees of the Participating Organization who are in Active Service and have selected the [$1,000 / $2,000 / $3,000 / $5,000] Plan.]

Dependents of Class 1 [and/or Class 2] who are in Active Service are eligible to enroll in the insurance plan.

HOSPITAL CONFINEMENT BENEFIT

Benefit Amount	[$1,000; $2,000; $3,000; $5,000] for the first
First Day Admission Benefit (Day 1)	Hospital admission occurring in the Plan Year

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

"Active Service" means a Covered Person is either 1) actively at work performing all regular duties either at his or her employer's place of business or someplace the employer requires him or her to be; 2) employed, but on a scheduled holiday, vacation day or period of approved paid leave of absence; or 3) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

"Covered Accident" means an accident that occurs while coverage is in force for a Covered Person and results in a Covered loss or Injury for which benefits are payable.

"Covered Person" means any eligible person, including Dependents if eligible for coverage under the Policy, and for whom the required premium is paid. If the cost for insurance is paid by the Participating Organization, individual applications are not required for an eligible person to be a Covered Person.

"Covered Sickness" means a Sickness that occurs while coverage is in force for a Covered Person and results in a loss for which benefits are payable.

"Dependent" means an Insured's lawful spouse or an Insured's child from the moment of birth to age 26. A child, for eligibility purposes, includes an Insured's natural child; adopted child, beginning with any waiting period pending finalization of the child's adoption; or a stepchild. A Dependent may also include any person related to the Insured by blood or marriage and for whom the Insured is allowed a deduction under the Internal Revenue Code.

Insurance will continue for any Dependent child who reaches the age limit and continues to meet the following conditions: 1) the child is handicapped, 2) is not capable of self-support and 3) depends mainly on the Insured for support and maintenance. The Insured must send Us satisfactory proof that the child meets these conditions, when requested. We will not ask for proof more than once a year.

If the Insured has elected coverage for a Dependent child, any newly born child of the Insured will be covered from the moment of birth for 31 days. Coverage may be continued beyond this time period if the Insured notifies Us within 31 days of the child's birth and pays any required premium.

["Dependent" also means an Insured's Domestic Partner. **"Domestic Partner"** means a person of the same or opposite sex of the Insured who:

1) shares the Insured's primary residence;
2) has resided with the Insured for at least 12 months prior to the date of enrollment and is expected to reside with the Insured indefinitely;
3) is financially interdependent with the Insured in each of the following ways;
    a. by holding one or more credit or bank accounts, including a checking account, as joint owners;
    b. by owning or leasing their permanent residence as joint tenants;
    c. by naming, or being named by the other as a beneficiary of life insurance or under a will;
    d. by each agreeing in writing to assume financial responsibility for the welfare of the other.
4) has signed a Domestic Partner declaration with Insured, if recognized by the laws of the state in which he or she resides with the Insured;
5) has not signed a Domestic Partner declaration with any other person within the last 12 months.
6) is 18 years of age or older;
7) is not currently married to another person;
8) is not in a position as a blood relative that would prohibit marriage.]

"Doctor" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

"Hospital" means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provide organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6) is not a place for drug addicts, alcoholics, or the aged.

We will not deny a claim for services rendered in any Hospital solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by:

1. the Joint Commission on the Accreditation of Hospitals; or
2. the American Osteopathic Association; or
3. the Commission on the Accreditation of Rehabilitative Facilities.

"Hospital Confined" or **"Hospital Confinement"** means a stay as a registered resident bed-patient in a Hospital.

"Immediate Family" means a Covered Person's parent, grandparent, spouse, child, brother, sister, grandchild or stepfamily members or in-laws.

"Injury" means accidental bodily harm sustained by a Covered Person from a Covered Accident which is the direct cause, independent of disease or bodily infirmity, of the Covered Loss. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

"Insured" means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a Dependent covered under the Policy.

"Life Status Change" means an event recognized by the Participating Organization and Us that qualifies the Insured to make changes in coverage at any time other than an Enrollment Period. The following events are all considered Life Status Changes:

1) marriage;
2) divorce, annulment or legal separation;
3) birth or adoption of a child;
4) change in a Dependent child's eligibility;
5) death of a spouse;
6) a change in the benefit plan or employment status of the Insured's spouse that affects either person's eligibility for benefits.

"Medically Necessary" means a treatment, service or supply that is: 1) required to treat an Injury or Sickness; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by {the Covered Person/Insured}'s condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) swimming pools or supplies for them; and 6) general exercise equipment are not Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used.

"Pre-Existing Condition" means an Injury or Sickness for which a Covered Person incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a person would have consulted a Doctor within 6 months before his or her most recent effective date of insurance. Pre-Existing Conditions will be covered after the Covered Person has been continuously covered under the Policy for 6 consecutive months.

"Plan Year" means, initially, the period of time from the Effective Date of the Policy until the first Policy Anniversary Date, and thereafter each subsequent 12 consecutive months provided coverage remains in force.

"Sickness" means illness or disease contracted by and causing loss to the Covered Person whose Sickness is the basis of claim. Any complications or any condition arising out of a Sickness for which the Covered Person is Hospital Confined will be considered a part of the original Sickness. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"We", "Our", "Us" means the insurance company underwriting this insurance or its authorized agent.

"You, Your, Yours" means the Insured.

ELIGIBILITY FOR INSURANCE

Each person in one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured on or after the Policy Effective Date. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

An Insured's Dependent is eligible on the latest of the date:
1. the Insured is eligible, if the Insured has Dependents on that date; or
2. the date the person becomes a Dependent.

In no event will a Dependent be eligible if the Insured is not eligible.

ENROLLMENT: The Insured and his or her Dependents may enroll for coverage within 31 days of becoming eligible for coverage through his or her employer, during the employer's open enrollment period, or within 31 days of a Life Status Change.

EFFECTIVE DATE OF INSURANCE

Insurance for an Insured or Dependent who enrolls during an enrollment period established by Us or within 31 days after he or she becomes eligible or within 31 days after a Life Status Change becomes eligible on the latest of the following dates:
1. the Policy Effective Date;
2. the date the first payroll deduction is authorized after he or she becomes eligible;
3. the first of the month following the date We receive the completed enrollment form; or
4. the date the required premium is paid.

Newborn and Adopted Children

Insurance for any newborn Dependent child automatically becomes effective from the moment of birth. Insurance for that Dependent child automatically ends 31 days later unless the Insured has other Dependent children insured under the Policy or within 31 days, makes a request to continue coverage for that child and pays the required premium, when due.

An adopted child of the Insured will be covered on the same basis as a newborn child from the date of placement for the purpose of adoption. Coverage continues unless the placement is disrupted and the child is removed from placement.

Deferred Effective Date

If an Eligible Person or Dependent is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service. A Dependent's insurance will not be in effect prior to the date the Insured is insured.

TERMINATION DATE OF INSURANCE

The Insured's coverage will end on the earliest of the date:
1. the Policy terminates;
2. the Insured is no longer eligible;
3. the period ends for which premium is paid;
4. the Insured is no longer in Active Service; or
5. the Participating Organization no longer participates under the Policy.

A Dependent's coverage will end on the earliest of the date:
1. he or she is no longer a Dependent;
2. the Insured's coverage ends; or
3. the period ends for which premium is paid.

Termination of insurance of any Covered Person will be without prejudice to any loss incurred before the date of termination.

CONTINUATION OF INSURANCE

If the Insured's Active Service ends for any reason, other than termination of employment for gross misconduct, insurance for an Insured and his or her covered Dependents will continue, if the required premium is paid, until the earliest of the following dates:

1. the eighteen-month period following the Insured's last day of full-time work;
2. for a covered Dependent, the date the Dependent is no longer eligible; or
3. the date the Policy terminates.

Any change in benefits that occurs during a period of continuation will apply on the date the Insured returns to Active Service.

REINSTATEMENT OF INSURANCE

If the Insured's insurance ends because he or she is no longer in Active Service, insurance may be reinstated for the Insured and his or her insured Dependents within 31 days of his or her return to Active Service.

The following conditions must be met for insurance to be reinstated:
1. the Policy remains in force.
2. the Insured and his or her Dependents are eligible under the Policy.

3. a written request for reinstatement is made.
4. the required premium is paid.

Any benefits paid during the Plan Year in which the Insured's and his or her Dependents' insurance is reinstated will be applied towards the benefit maximums for that Plan Year.

Reinstated insurance will be effective on the later of the date the Insured returns to Active Service or the date the required premium and written request for reinstatement are received by Us. We will not pay benefits while insurance is not in force under the Policy.

DESCRIPTION OF BENEFITS

The following provisions explain the benefits and exclusions applicable under the Policy. Please see the *Schedule of Benefits* for the applicability of these benefits.

HOSPITAL CONFINEMENT BENEFIT

We will pay the First Day Admission Benefit shown in the Schedule of Benefits for the first day of the first Hospital Confinement occurring in the Plan Year when the Covered Person is admitted as an inpatient in a Hospital, if:

1. the admission to the Hospital is for the treatment of a covered Injury or Covered Sickness; or
2. the admission occurs within 7 days of the date of a Covered Accident; and
3. the admission is ordered by a Doctor as Medically Necessary; and,
4. coverage under the Policy is in force when the admission occurs.

GENERAL EXCLUSIONS

We will not pay benefits for any Covered Accident or Covered Sickness or any period of Hospital Confinement covered by this Policy that is caused by, or results from:

1. intentionally self-inflicted injury; suicide or attempted suicide.
2. war or any act of war, whether declared or not.
3. active participation in a riot or insurrection.
4. service in the military, naval or air service of any country or international organization.
5. alcoholism, the voluntary use of illegal drugs, the intentional taking of over-the-counter medication not in accordance with recommended dosage and warning instructions, intentional misuse of prescription drugs [if issued outside of DC: alcoholism, drug addiction or the use of any drug or narcotic, except as prescribed by a Doctor].
6. travel or activity outside the United States or Canada.
7. Injury or death to which a contributing cause is the Covered Person's violation or attempt to violate any duly-enacted law, or the commission or attempt to commit an assault or a felony, or other criminal activity, or that occurs while the Covered Person is engaged in an illegal occupation.
8. services, supplies or a period of confinement ordered by persons employed or retained by a Participating Organization, or by any Immediate Family or member of the Covered Person's household;
9. dental surgery, unless the surgery is the result of a Covered Accident or Covered Sickness.

[10. Pre-existing Conditions, except for congenital anomalies of a covered Dependent child.]

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

CLAIM PROVISIONS

Notice of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by the Policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number.

Claim Forms: Upon receiving written notice of claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

Proof of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible.

Claimant Cooperation Provision: Failure of a claimant to cooperate with the Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Time Payment of Claims: Any benefits due will be paid when We receive written (or authorized electronic or telephonic) proof of loss.

Payment of Claims: If the Insured dies, any benefits unpaid at the time of the Insured's death will be paid to the beneficiary Our records indicate the Insured designated for these plan benefits.

If there is no named beneficiary or surviving beneficiary on record with Us or Our authorized agent, We pay benefits in equal shares to the first surviving class of the following: 1) Spouse; 2) Children; 3) Parents; 4) Brothers and sisters. If there are no survivors in any of these classes, We will pay the Insured's estate.

All other benefits will be paid to the Insured. If the Insured is: (1) a minor; or (2) in Our opinion unable to give a valid release because of incompetence, We may pay any amount due to a parent, guardian, or other person actually supporting him or her. Any payment made in good faith will end Our liability to the extent of the payment.

Beneficiary: The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. The name of the beneficiary is not effective until entered on the records of the Participating Organization. We are not responsible for the correctness of the records.

If the Covered Person is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received,

the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

The Insured is the beneficiary for any covered Dependent.

All benefit payments under this Policy will be made in the United States of America in the currency of the United States of America.

Physical Examinations and Autopsy: We have the right to have a Doctor of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy before 60 days following the date proof of loss was given to Us. No such action can be brought after expiration of the applicable statute of limitations from the time written proof of loss is required to be furnished.

Recovery of Overpayment: If benefits are overpaid or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods:

1. A request for lump sum payment of the amount overpaid or paid in error.
2. Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

ADMINISTRATIVE PROVISIONS

Changes in Premium Rates: We may change the premium rates from time to time with at least 31 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a12-month period. However, We reserve the right to change rates at any time if any of the following events take place:

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Payment of Premium: The first Premium is due on the Policy Effective Date. After that, premiums will be due monthly unless We agree with the Participating Organization on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period: A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Participating Organization will be liable to Us for any unpaid premium for the time the Policy was in force.

Your Grace Period: If the required premium is not paid on the Premium Due Date, there is a 31-day grace period after each Premium Due Date after the first. If the required premium is not paid during the Grace Period, this insurance, and insurance for Your Dependents will end on the last day of the period for which premium was paid.

If benefits are payable during the Grace Period, We will deduct any overdue premium from the proceeds payable under the Policy.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy (including any endorsements or amendments), the signed applications of the Policyholder, any Participating Organization and any individual applications of Covered Persons, are the entire contract. No statement made by the applicant shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application signed by the applicant.

To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by Our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

Incontestability: Any statements made by the Participating Organization or Covered Persons will be treated as representations and not warranties. No such statement will cause Us to deny or reduce benefits or be used as a defense to a claim, unless the written instrument containing the statement is signed by and is, or has been, furnished to such person. In case of the death or incapacity of the Covered Person such statement will be furnished to the Covered Person's beneficiary or representative.

After two years from the Covered Person's effective date of coverage, or from the effective date of any added or increased benefits, no such statement will cause coverage to be contested except for nonpayment of premiums or eligibility for coverage.

Clerical Error: If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms.

Certificates of Insurance: We will deliver a certificate of insurance to the Policyholder for delivery to each Covered Person. Each certificate will list the benefits, conditions and limits of this Policy. It will state to whom the benefits are payable under the Policy.

Conformity with State Laws: On the effective date of the Policy, any provision that is in conflict with the laws of the state where it is issued is amended to conform to the minimum requirements of such laws.

Not in Lieu of Workers' Compensation: The Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.