Better benefits at work.

Leech Lake Band of Ojibwe

Hospital Insurance

can pay benefits that help you with the costs of a covered hospital visit.

How does it work?

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. The money is paid directly to you – not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.

What's included?

- $1,500 for each covered hospital admission – once per year
- $100 for each day of your covered hospital stay, up to 60 days – once per year
- $200 for each day you spend in intensive care, up to 15 days – once per year
- $150 for emergency room treatment for a covered accident – once per year
- $100 for ambulance or $500 for air ambulance transportation for a covered accident – once per year

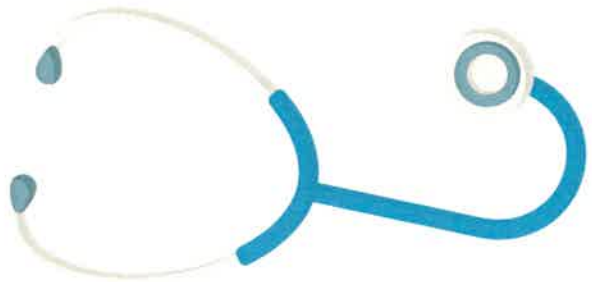
Why is this coverage so valuable?

- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.

Who can get coverage?

You:	If you're actively at work
Your spouse:	Ages 17 and up
Your children:	Dependent children until their 26th birthday, regardless of marital or student status.

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.



This plan has a pre-existing condition limitation. See the disclosures for more information.

How much does it cost?

Hospital Insurance Weekly rates				
Age	Employee	Employee and spouse	Employee and child	Employee spouse and child
17-49	$3.80	$7.62	$5.98	$9.79
50-59	$4.80	$9.89	$6.98	$12.07
60-64	$6.68	$13.81	$8.86	$15.99
65+	$9.99	$20.74	$12.17	$22.92

For illustrative purposes only. Actual cost may vary. Family coverage options assume employee and spouse are in the same age band. If employee and spouse are in different age bands, the final Weekly premium amounts will be different.
Coverage becomes effective on the first day of the month in which payroll deductions begin.

Hospital Insurance

Hospital insurance filed policy name is Hospital Confinement Indemnity Group Insurance Policy

Exclusions and Limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- Participating in war or act of war, whether declared or undeclared;
- Committing acts of terrorism;
- Treatment for alcoholism or drug addiction unless the insured individual is addicted to a narcotic taken on the advice of a physician;
- Treatment for dental care or dental procedures, unless treatment is the result of a covered accident;
- Elective procedures and/or cosmetic surgery or reconstructive surgery, unless it is as a result of trauma, infection or other diseases;
- Participating or attempting to participate in a felony or being engaged in an illegal occupation;
- Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- Hospital confinement caused by, contributed to by, or resulting from mental illness. However, dementia as a result of stroke, trauma, viral infection, Alzheimer's disease or other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment are covered under this policy;
- Any hospital confinement of a newborn following the birth unless the newborn is sick or injured.
- Any pregnancy of a dependent child, including services rendered to her child after birth. The definition of hospital does not include certain facilities. See your contract for details.

Pre-existing conditions

Benefits for a pre-existing condition (defined as a sickness or injury, or symptoms of a sickness or injury, whether diagnosed or not, for which you received medical treatment, consultation, medical advice, care or services, including diagnostic measures, took prescribed drugs or medicine, or had been prescribed drugs or medicine to be taken during the 12 months prior to your effective date) will not be paid if the date of the covered loss occurs during the first 12 months after your effective date.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer.

Otherwise, your coverage under the policy ends on the earliest of the:

- Date this policy is cancelled;
- Date you are no longer in an eligible group;
- Date your eligible group is no longer covered;
- Date of your death;
- Last day of the period for which you made any required contributions; or
- Last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the Portability provision or in accordance with the layoff and leave of absence provisions of this policy.

Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

This coverage is a supplement to health insurance. It is not a substitute for comprehensive health insurance and does not qualify as minimum essential health coverage.

Individuals must have comprehensive medical coverage to be eligible for this hospital indemnity insurance.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to policy form GHI-1 or contact your Unum representative.

Unum complies with all state civil union and domestic partner laws when applicable.

Underwritten by:
Unum Life Insurance Company of America, Portland, Maine

GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE
EVIDENCE OF INSURABILITY

Instructions for Application

IMPORTANT: PLEASE FILL OUT ALL SECTIONS FULLY AND COMPLETELY BASED ON THE INSTRUCTIONS BELOW.
If there are unanswered questions or missing information on the application, it may delay consideration of your application for insurance.

Instructions for Application

Definition of Application Type: Check the applicable application type:

- **Newly Eligible:** Application for insurance on a newly eligible or newly hired employee, usually a new employee applying for this coverage.
- **Change to Existing Coverage:** Application for insurance for requested changes to an existing Unum policy.
- **Replace Existing Unum Coverage:** Change from existing to later or updated version of this product. Evidence of Insurability may be required. A new policy/certificate will be issued to replace the existing policy
- **Late Applicant:** Application for insurance for a previously eligible employee. An individual is considered to be a late applicant if working for the employer in an eligible group and the period within which coverage could first be applied for without Evidence of Insurability has passed.
- **Rehire:** If employment ends with this group and you are rehired.

Section 1: Enrollment in a Qualified Medical Plan

Section 2: Employee Information
Fully complete this section making certain to answer any and all questions completely and accurately. Information regarding your employer's name and address, as well as your personal information must be provided. (See your Plan Administrator if further information is needed.)

Section 3: Spouse Information
Complete this information if applying for Spouse coverage. Fully complete this section making certain to answer any and all questions completely and accurately.

Section 4: Coverage Information
Make no more than one selection. If assistance is required for completion, please contact your Plan Administrator.

Section 5: Medical Profile
Complete as required for all underwritten coverage.

Section 6: Employee (Applicant) Statements
This section is required to be completed. This application cannot be processed if you fail to sign and date the application.

APPLICATION FOR GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE
Evidence of Insurability

Unum Life Insurance Company of America ("Unum")
2211 Congress Street • Portland, Maine 04122

Application Type: ☐ Newly Eligible ☐ Late Applicant ☐ Replace Existing Unum Coverage
☐ Change to Existing Coverage ☐ Rehire

THE APPLICANT MUST BE ENROLLED IN A QUALIFIED MAJOR MEDICAL PLAN PRIOR TO APPLYING FOR THE GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE

SECTION 1: Enrollment in a qualified major medical plan. Complete for all applicable applicants.

Are you/your dependents enrolled in a Qualified Major Medical Health Plan?

Employee	☐ Yes	☐ No
Spouse	☐ Yes	☐ No (if applicable)
Dependent Child(ren)	☐ Yes	☐ No (if applicable)

If the answer is "Yes", please complete the application and submit it. If the answer is "No", do NOT apply for this Group Hospital Confinement Indemnity Insurance coverage for anyone who is not enrolled in a Qualified Major Medical Health Plan.

SECTION 2: Employee (Applicant) Information – Always Complete

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender ☐ F ☐ M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #
Email Address		Employee ID/Payroll #
Employer Name		Date of Hire (mm/dd/yyyy)
Street/PO Box		Occupation
City		
State	Zip Code	Work Phone #
Are you Actively at Work? ☐ Yes ☐ No		Scheduled Number of Work Hours/week

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

SECTION 3: Spouse Information – Complete Only if applying for Spouse Coverage

Name (First, Middle, Last)		Social Security Number
Gender ☐ F ☐ M	Does the Spouse live in the U.S.? ☐ Yes ☐ No	Date of Birth (mm/dd/yyyy)

Employee Name: _____ Employee SSN: _____

SECTION 4: Coverage Information – Complete for Employee (Applicant) and for Spouse (if applicable)

☐ Employee (only) ☐ Employee & Spouse ☐ Employee & Dependent Child(ren)
☐ Employee, Spouse, & Dependent Child(ren)

	Employee (Applicant)	Spouse
Will coverage applied for replace or modify any existing Unum insurance coverage?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes," provide details below:

Insured's Name	Policy Number
Total Cost per Pay Period	$

SECTION 5: Medical Profile – Complete as required for all underwritten coverage

	Employee (Applicant)	Spouse
1. Current height and weight	___ ft. ___ in. ____ lbs.	___ ft. ___ in. ____ lbs.
2. Have you (applicant) or your spouse (if applying) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 3 years, have you (applicant) or your spouse (if applying) received medical advice, sought treatment, including medication, or been hospitalized for any of the following:	☐ Yes ☐ No	☐ Yes ☐ No

- Atrial fibrillation, angina, heart attack, coronary artery disease, heart surgery, congestive heart failure, cardiomyopathy, or heart valve disease
- Stroke/transient ischemic attack (TIA), aneurysm
- Vascular disease excluding varicose veins
- Chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis (excluding asthma)
- Cirrhosis of the liver, hepatitis (other than A)
- Diabetes (other than gestational or diet controlled)
- Alcohol or drug usage
- High blood pressure with a systolic reading (top number) greater than 166 or a diastolic reading (lower number) greater than 100
- Kidney disease or failure (excluding kidney stones)
- Musculoskeletal disease not related to an accidental injury (excluding carpal tunnel syndrome or osteoarthritis)
- Neurological disease excluding headache or epilepsy if no seizure in the last 3 years
- Schizophrenia, psychosis, major depressive disorder, bipolar disorder or post traumatic stress disorder
- Cancer or malignancy of any kind including leukemia, Hodgkin's disease or skin cancer (excluding basal cell or squamous cell carcinoma of the skin)

Employee Name: _____ Employee SSN: _____

SECTION 6: Employee (Applicant) Statements

I understand the effective date of coverage issued based on this application is subject to the application being acceptable under the rules, limits and standards of Unum Life Insurance Company of America (hereafter Unum) and the insurance is, or would have been, issued as applied for (or if not issued as applied for, then as modified). The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. If I pay part or all of the cost of my coverage, the effective date will not be earlier than the first of the month in which payroll deductions begin.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

All statements and answers provided on this application are true and complete, and are given to obtain insurance.

CAUTION: Unum Life Insurance Company of America will rely on the information provided in order to evaluate this application. If the answers provided are incorrect or untrue, Unum Life Isnurance Company of America may deny benefits or rescind insurance. Any person who, submits an application, files a claim or helps commit fraud agains an Insurer is guilty of a crime.

Employee (Applicant) Signature	Date (mm/dd/yyyy)

INSTRUCTIONS

Complete the information below only if you or any person proposed for coverage on the preceding application is currently eligible for Medicare. To be eligible for Medicare, you must be either: (1) age 65 or older; or (2) disabled.

Medicare Certification Form

This is to certify that I have received the "Medicare Supplement Buyer's Guide" and the "Important Notice to Persons on Medicare."

Employee (Applicant) Signature	Date (mm/dd/yyyy)