SERFF Tracking #:	*ANTX-129000350*	***State Tracking #:***		***Company Tracking #:***	*USAHC RATE*

State:	*District of Columbia*	***Filing Company:***	*Standard Life and Accident Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*GR ASSOC HOSPITAL INEMNITY-RATES*		
Project Name/Number:	*GR ASSOC HOSPITAL INEMNITY-RATES/GR ASSOC HOSPITAL INEMNITY-RATES*		

Form Schedule

Lead Form Number: SLA-CI11-GAP

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Group Policy	SL-USAHC - P	POL	Initial		50.100	MASTER Policy.pdf
2		Group Certificate	SL-USAHC-C	CER	Initial		50.100	Generic Cert.pdf
3		Group Policy Application	USAHC HI APP	AEF	Initial		50.100	executed Master APP.pdf
4		Group Enrollment Form	SLAICOUSAHC-DC	AEF	Initial		50.100	DC Enrollment Form.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Standard Life and Accident Insurance Company

Home Office: One Moody Plaza, Galveston, Texas, 77550
Toll-Free Telephone Number: 1-888-350-1488
(A Stock Insurance Company hereafter referred to as "Standard Life", "We", "Us", "Our" or "the Company")

GROUP HOSPITAL INDEMNITY SUPPLEMENTAL INSURANCE POLICY

This Policy is issued to the Policyholder by the Company on the Policy Effective Date at 12:01 am Standard Time at the Policyholder's place of business and ends at 12:01 am Standard Time on the termination date. Policy anniversaries are deemed to occur each year on the 1st of the corresponding month of the Policy Effective Date.

This Policy is a legal contract between the Policyholder and the Company. The Company agrees to insure eligible persons of the Policyholder against loss covered by this Policy in exchange for the payment of the required premium. Coverage is subject to the terms, conditions, limitations, and exclusions described in the Policy. This Policy is non-participating.

TERMINATION. This Policy may be terminated by the Company for reasons stated in the Termination provision.

PREMIUMS. The Company may change premiums for coverage. Premiums may be changed and are due as stated in the **Premiums** provision.

30 DAY RIGHT TO EXAMINE POLICY. Within 30 days after the Policyholder receives this Policy, it may be returned in person or by regular mail to the Company, its agency office or the agent who sold it to the Policyholder for any reason. The Company will return the premium to the payee. Then the Policyholder and the Company will be in the same position as if a Policy had never been issued.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If any Covered Person is eligible for Medicare, such person should review the "Guide to Health Insurance for People with Medicare" available from the Company.

This Policy is governed by the laws of the state in which the Policy was issued and delivered.

Signed for Us on the Policy Effective Date.

Secretary

President

NOTICE TO BUYER:
THIS IS A LIMITED BENEFIT POLICY. IT IS NOT A MAJOR MEDICAL OR COMPREHENSIVE HEALTHCARE POLICY. IT IS NOT DESIGNED TO COVER ALL MEDICAL EXPENSES. PLEASE READ THIS POLICY CAREFULLY!

NO BENEFITS ARE PAYABLE FOR SICKNESS DURING THE FIRST 30 DAYS FOLLOWING A COVERED PERSON'S EFFECTIVE DATE.

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POLICY SCHEDULE OF BENEFITS

GROUP POLICYHOLDER: [United Service Association For Health Care]
GROUP POLICY NUMBER: [SLA012345]
POLICY EFFECTIVE DATE: [June 1, 2013]
ANNIVERSARY DATE: [June 1st]
STATE OF ISSUE: District of Columbia

COVERAGE AMOUNTS CHOSEN BY THE INSURED WILL BE SHOWN IN THE CERTIFICATE SCHEDULE OF BENEFITS.

HOSPITAL BENEFIT:

[Hospital Admission Benefit: .....[$0 – $10,000]]

Hospital Confinement Benefit:

[Elimination Period
Sickness……[0][3][7] Days]

Daily Hospital Confinement Benefit……..……..[$50 - $2,000] Per Day

Maximum Hospital Confinement Benefit Period ……...[10][15][30][60][90][365] Days

Intensive Care Unit Benefit:

Daily Intensive Care Unit Benefit .....[$50 – $2,000] Per Day

Maximum Intensive Care Unit Benefit Period ..... [10][15][20][30] Days

CONTINUOUS CARE BENEFIT:

Daily Benefit..... [$25 – $500] Per Day

Maximum Continuous Care Benefit Period..... [the length of the preceding Period of Confinement in a Hospital not to exceed [10][15][30] days of care]

EMERGENCY MEDICAL SERVICES BENEFIT:

Emergency Medical Services Benefit…… $25 Per Visit
(Payable Once Per Year Per Covered Person)

PREMIUM RATES:

Premiums are shown on the Certificate Schedule of Benefits.

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DEFINITIONS - GENERAL

Accident or Accidental means an act or event which is unforeseen, unexpected and unanticipated, definite as to time and place, which:
1. causes Injury to one or more Covered Persons; and
2. occurs while coverage is in effect for the Covered Person.

Age means a Covered Person's Age as of his/her last birthday.

Certificate means the Certificate of Insurance issued to the Insured. It describes the coverage under this Policy.

Certificate Effective Date is the date coverage begins for each Covered Person under this Policy. It will be different for a Covered Person added to this Policy after the original date of issue or when a change in coverage for any Covered Person occurs. Each Covered Person's Certificate Effective Date is shown in the Certificate's Schedule of Benefits.

Complications of Pregnancy means:
1. conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but does not include false labor, pre-term or premature labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Covered Person means an Insured, an Insured's Spouse or Dependent children:
1. whom the Insured has elected to cover under this Policy;
2. for whom premium has been paid; and
3. listed as a Covered Person in the Certificate Schedule of Benefits.

The Insured must be listed as a Covered Person in order to be covered under this Policy.

Dependent means an Insured's family as follows:
1. A lawful Spouse*, if not legally separated or divorced;
2. Unmarried children (whether natural, adopted or stepchildren) under the limiting age of 26; or
3. Unmarried children for whom an Insured is required to provide insurance under a medical support order or an order enforceable by a court.

*The term "Spouse" as used throughout this Policy will also means an Insured's legal Domestic Partner.

Domestic Partner means a person with whom an Insured maintains a committed relationship and with whom an Insured has registered as domestic partners by executing a declaration of domestic partnership filed with the with the appropriate state agency. Each partner must:
1. Be at least 18 years old and competent to contract;
2. Be the sole domestic partner of the other person; and
3. Not be married.

[Elimination Period means the consecutive number of days the Covered Person is confined as an Inpatient before a benefit is payable.]

Enrollment Application means the form(s) that the Insured (and the Insured's spouse, if any) signed to apply for coverage under this Policy. It also includes any other document approved by the Company that the Insured uses to apply for or change coverage under this Policy.

Home Health Care means a program of professional, paraprofessional or skilled care provided through a Home Health Care Agency to a Covered Person in his or her home. This care is limited to the following:
1. Nursing services provided by a:
   (a) registered nurse;
   (b) licensed practical nurse;
   (c) licensed vocational nurse; or
   (d) a licensed public health nurse;
2. Physical therapy;
3. Speech therapy;

4. Respiratory therapy; or
5. Occupational therapy.

Home Health Care Agency means an agency or organization which provides Home Health Care services, and:
1. Is licensed or certified, if required by the jurisdiction in which it is located; or accredited by:
   (a) the National Home Caring Council, a Division of the Foundation for Hospice and Home Care;
   (b) the Joint Commission Accreditation of Health Care Organizations; or
   (c) the National League for Nursing;
2. Is supervised by a qualified professional such as a registered nurse or a licensed social worker;
3. Whose employees receive appropriate specialized training; and
4. Keeps clinical records, including Physician's orders where appropriate, on all patients.

Hospice means a licensed agency, organization, or unit that provides a centrally administered and autonomous continuum of palliative and supportive care to terminally ill persons and their families. The care must be directed and coordinated by the Hospice organization and received primarily in the patient's home, or on an outpatient or short-term inpatient basis in a Hospice unit.

Hospital means a legally operated institution licensed by the state in which it is located that maintains and uses a laboratory, X-ray equipment and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises.

The term "Hospital" does not include any institution or part thereof used as a Rehabilitation Unit or Rehabilitation Facility; a Hospice unit, including any bed designated as a Hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended-care facility; a Skilled Nursing Facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

Immediate Family Member means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild.)

Injury or Injuries means Accidental bodily Injury sustained by a Covered Person in an Accident that:
1. is the direct cause of the condition for which benefits are provided,
2. is independent of disease or bodily infirmity or any other cause, and
3. occurs while this insurance is in force.

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

Inpatient means confined overnight as a registered bed patient in a Hospital where at least one day's room and board is charged. Inpatient does not include a Covered Person's treatment in an ambulatory surgical center, emergency room, or an observation room. The confinement must be Medically Necessary.

Insured means the Association member described in the Enrollment Application, any successor thereof, or, in the case of the death of the Association Member, any person thereafter named to assume ownership privileges under this Policy. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person. The Insured must be listed as a Covered Person in the Certificate Schedule of Benefits and appropriate premium paid in order to be covered under this Policy.

Intensive Care Unit (ICU) means a specifically designated unit of the Hospital that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The ICU must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the ICU on a full-time basis. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (1) Intensive Care Units, (2) Cardiac Intensive Care Units, and (3) Infant (Neonatal) Intensive Care Units.

Medically Necessary means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of Injury or Sickness. We do not consider a service or supply as Medically Necessary if:

1. it is provided only as a convenience to the Covered Person or provider;
2. it is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. it is experimental or investigational.

The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Policy.

Outpatient means the Covered Person is not confined in a Hospital.

Period of Confinement means a time period of continuous confinement as an Inpatient in a Hospital. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated Injury or Sickness or the confinements are separated by [30-180] days.

Physician means a licensed practitioner of the healing arts acting within the scope of his or her license who is not:

1. the Covered Person; or
2. an Immediate Family Member.

Policyholder means the entity to which this Policy is issued.

Pre-existing Condition means a condition not otherwise excluded by name or specific description:

1. for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Physician within [6 – 12] months before the Certificate Effective Date; or
2. that would have caused a reasonable person to seek medical diagnosis or treatment within [6 – 12] months before the Certificate Effective Date.

Rehabilitation Facility means an institution whose primary purpose is to provide restorative therapy to disabled persons. Such facility must be licensed as such in the state in which it operates. "Rehabilitation Facility" does not include places for custodial care or places for confinement of drug addicts or alcoholics.

Rehabilitation Unit means a unit of a Hospital providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Sickness means Sickness or disease which begins while coverage is in force under this Policy for the Covered Person. Sickness does not include normal pregnancy, but does include Complications of Pregnancy.

All related conditions and recurring symptoms of Sickness will be considered one Sickness.

Skilled Nursing Facility means a lawfully operating institution or a distinct part thereof. Such facility must be engaged mainly in providing skilled nursing care and treatment for people convalescing from an Injury or Sickness. It must: (1) have organized facilities for medical services; (2) provide 24 hour a day nursing services under the full-time supervision of a Physician or a registered nurse; (3) have available the services of a Physician at all times; (4) maintain daily clinical records on each patient; and (5) provide appropriate methods for dispensing and administering drugs and medicines.

A Skilled Nursing Facility shall include the following facilities that are operating within the scope of their lawful licenses: (1) a rehabilitation center; (2) a transitional care unit; (3) an intermediate nursing facility; (4) an extended care facility; and (5) a nursing home.

A Skilled Nursing Facility does not mean a home or facility, or part of home or facility, that is used primarily for: (1) rest; (2) the aged; (3) alcoholics or drug addicts; (4) mental illness or disorders; (5) custodial care; or (6) educational care.

Waiting Period means a consecutive 30 day period of time starting with the Certificate Effective Date for each Covered Person during which no benefits are payable for a Sickness.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBILITY
An Applicant, the Applicant's Spouse, and any of the Applicant's Dependent children may apply for Policy coverage. We must find each Proposed Insured acceptable based on Our rules in effect at the time the applicant completes the Enrollment Application.

No Proposed Insured may be eligible for insurance under this Policy as both an Insured and as a Spouse or Dependent Child at the same time. If an Insured and Spouse are both eligible to be covered as an Insured, one but not both, is eligible to cover the Dependent Children. The other Spouse may elect single coverage only.

ON THE CERTIFICATE EFFECTIVE DATE
The Insured's Certificate Schedule of Benefits shows Covered Persons initially covered under the Policy. The insurance for a Covered Person will take effect on the Certificate Effective Date assigned by Us and shown in the Insured's Certificate Schedule of Benefits.

AFTER THE CERTIFICATE EFFECTIVE DATE
Eligible persons may apply for coverage after the Certificate Effective Date. The eligible person must complete a new application and submit evidence of insurability if requested by Us. Acceptance for coverage will be in accordance with Our rules in effect on any application date. The insurance for a Covered Person will take effect on the Certificate Effective Date assigned by Us.

NEWBORN CHILDREN
The Insured's newborn child is automatically covered from the moment of birth until such child is 31 days old. Coverage for newborns shall be the same as for other covered Dependents. If the Insured does not have other covered Dependents and wants uninterrupted coverage, the Insured will have the option to add Dependent child coverage to the Insured's coverage. The Insured must notify the Company in writing within 31 days of such birth and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 31 day period.

ADOPTED CHILDREN
An adopted child is automatically covered for the first 31 days from the date of placement for the purpose of adoption by the Insured or the date of the entry of an order granting the Insured custody of the child. Coverage for such child will be the same as for other covered Dependents. If the Insured does not have other covered Dependents and wants uninterrupted coverage, the Insured will have the option to add Dependent child coverage to the Insured's coverage. The Insured must notify the Company in writing within 31 days of the date of placement or the date of the entry and pay the required additional premium (if any), in order to have coverage for the adopted child continue beyond such 31 day period.

Coverage for a child that is placed with an Insured for adoption will continue in accordance with the provisions of this Policy, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

TERMINATION AND CONTINUATION

POLICY TERMINATION

The Company or the Policyholder can terminate or non-renew coverage under this Policy as of any premium due date under any of the following conditions:

1. We or the Policyholder requests termination of this Policy;
2. The Policyholder or Insured has failed to pay premiums in accordance with the terms of this Policy or We have not received timely premium payments; or
3. The Policyholder, Insured or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the provision titled Time Limit on Certain Defenses.

If coverage is non-renewed under number 1 by the Policyholder, the Policyholder is responsible for providing each Insured notice of such termination. If coverage is non-renewed under number 1 by the Company, We will provide at least 60 days advance written notice to the Policyholder and each Insured.

If We refuse to renew coverage under reason number 2, We will provide 30 days written notice of termination of coverage prior to the non-renewal date in accordance with the Grace Period.

At the time of coverage renewal, We may modify coverage under this Policy. However, the modification must be consistent with State law and effective on a uniform basis among all individuals that We cover under this Policy.

Subject to the conditions listed above, We cannot refuse to renew coverage:

1. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
2. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

Termination of coverage will not affect a claim for a covered loss that occurred while the Insured's coverage was in force under this Policy.

TERMINATION DATE OF A COVERED PERSON

Coverage under this Policy for a Covered Person ends on the earliest of:

1. the date this Policy is terminated by the Company or the Policyholder;
2. the premium due date if premiums are not paid when due, subject to the Grace Period;
3. the date a Covered Person performs an act or practice that constitutes fraud;
4. the date the Insured requests, in writing, that the coverage be terminated; or
5. the date the Dependent does not meet the definition of a Dependent under this Policy.

If coverage is non-renewed under number 1 by the Policyholder, the Policyholder is responsible for providing each Insured notice of such termination. If coverage is non-renewed under number 1 by the Company, We will provide at least 60 days advance written notice to the Insured.

If We refuse to renew coverage due to non-payment of premiums, We will provide 30 days written notice of termination of coverage prior to the non-renewal date in accordance with the Grace Period.

At the time of coverage renewal, We may modify coverage under this Policy. However, the modification must be consistent with State law and effective on a uniform basis among all individuals that We cover under this Policy.

Subject to the conditions listed above, We cannot refuse to renew coverage:

3. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
4. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

Termination of coverage will not affect a claim for a covered loss that occurred while the coverage was in force under this Policy.

CONTINUATION OF AN INCAPACITATED CHILD
If a Dependent child reaches the limiting age as defined in the definition of Dependent and continues to be both:
(a) incapable of self-sustaining employment by reason of mental incapacity or physical handicap; and (b) remains dependent upon the Insured for support and maintenance, coverage for such child will continue while the coverage is in force and so long as such incapacity continues and the applicable premium is paid.

Satisfactory proof must be submitted to Us by the Insured within 31 days of such termination date. During the next two years we may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year. The premium for such child's continued coverage will be the same as for an adult of like age and gender.

CONTINUATION PROVISION
The following Covered Persons are eligible to continue coverage under this Policy if coverage is terminated for reasons other than non-payment of premium or fraud:
1. a Spouse and covered Dependent children in the event of the death of the Insured;
2. a Spouse in the event of legal dissolution of the marriage.

In the event of the Insured's death when there is not a covered Spouse, coverage ends for all Covered Persons on the date of the Insured's death.

To continue insurance under this Policy, the Spouse must:
1. become a member of the Association to which this Policy was issued;
2. submit a request to Us within 31 days after coverage under their Certificate terminates; and
3. timely pay the required premium.

Premium rates for coverage under this continuation will be based on the Covered Person's class at the time of election. If the Covered Person does not elect to continue insurance within 31 days after the coverage ends, coverage may not be elected under this provision at a later date.

Coverage under the new Certificate will begin for a Covered Person on the date coverage terminates under the earlier Certificate. Any benefits paid under the earlier Certificate will be deducted from benefits payable under the new Certificate. Benefits paid under the earlier Certificate, together with benefits payable under any new Certificate that may be issued, will not exceed those that would have been payable had the Covered Person's insurance under the earlier Certificate remained in force and effect.

BENEFITS AND COVERAGES

Benefits described below are payable as stated in the Certificate Schedule of Benefits when a Covered Person incurs charges for Medically Necessary treatment while coverage is in force, subject to any applicable terms, exclusions or limitations. Benefits for Sickness are subject to the Waiting Period.

HOSPITAL BENEFITS

[Hospital Admission Benefit:

If a Covered Person is admitted as an Inpatient in a Hospital for treatment of Sickness or Injury, the Company will pay the Hospital Admission Benefit shown in the Certificate Schedule of Benefits.

The Hospital Admission Benefit is payable once during each Period of Confinement.]

Hospital Confinement Benefit:

If a Covered Person is confined as an Inpatient in a Hospital for treatment of Sickness or Injury, the Company will pay the Daily Hospital Confinement Benefit shown in the Certificate Schedule of Benefits for each day that a Covered Person is charged for room and board as Inpatient care.

The Daily Hospital Confinement Benefit is payable up to the Maximum Hospital Confinement Benefit Period shown in the Certificate Schedule of Benefits for each Period of Confinement.

No benefits are payable during the Waiting Period [or Elimination Period] for Sickness. [The Elimination Period does not run concurrently with the Waiting Period and must be satisfied after the Waiting Period has been met.]

We do not provide benefits for treatment received in an emergency room, any Outpatient setting, skilled nursing facility, rehabilitation facility, rehabilitation Unit, hospice or any other facility other than a Hospital.

Intensive Care Unit Benefit:

While a Covered Person is receiving the Hospital Confinement Benefit due under this Policy, the Company will pay an additional benefit equal to the Daily Intensive Care Unit Benefit shown in the Certificate Schedule of Benefits for each day a Covered Person is confined in and charged for an Intensive Care Unit.

The Daily Intensive Care Unit Benefit is payable for up to the Maximum Intensive Care Unit Benefit Period shown in the Certificate Schedule of Benefits for each Period of Confinement.

CONTINUOUS CARE BENEFIT

If a Covered Person is receiving Inpatient care in a Hospital and upon discharge requires Continuous Care, We will pay the Daily Benefit for each day up to the Maximum Continuous Care Benefit Period shown in the Certificate Schedule of Benefits.

Continuous Care means care received in a Skilled Nursing Facility, Rehabilitation Facility, Rehabilitation Unit or Home Health Care or Hospice care in connection with the condition for which he or she was hospitalized.

The following conditions must be met before Continuous Care benefits are payable:

1. Continuous Care must begin within 7 days following discharge from Inpatient care in a Hospital;
2. Continuous Care must be for the same Accident or Sickness for which the Covered Person was hospitalized;
3. The Continuous Care must be prescribed by a Physician and must be Medically Necessary for the care and treatment of the Covered Person's condition;
4. Home Health Care services must be performed by a Home Health Care Agency. Home Health Care services cannot be performed by a person who lives with the Covered Person or by the Covered Person's Immediate Family Member;
5. Hospice care services require: (a) a written statement from the attending Physician that the Covered Person has a life expectancy of six (6) months or less, and (b) a written statement from the Hospice certifying the days that services were provided.

The Daily Benefit is payable once per day regardless of how many Continuous Care services are provided on that day. Benefits are not payable if the Covered Person is Hospital confined on an Inpatient basis.

EMERGENCY MEDICAL SERVICES BENEFIT

If a Covered Person receives Emergency Medical Services for the treatment of a Medical Emergency, the Company will pay the Emergency Medical Services Benefit as shown in the Certificate Schedule of Benefits.

As used in this provision:

“Ancillary Services" means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

“Emergency Medical Services” means:

1. Health care services furnished in the emergency department of a Hospital for the treatment of a Medical Emergency;
2. Ancillary Services routinely available to the emergency department of a Hospital for the treatment of a Medical Emergency; and
3. Emergency Medical Services transportation (air or ground ambulance).

"Medical Emergency" means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

EXCLUSIONS AND LIMITATIONS

WAITING PERIOD FOR SICKNESS:

Loss caused by or relating to Sickness will not be covered for this first 30 days after the Certificate Effective Date of each Covered Person.

PRE-EXISTING CONDITION LIMITATION:

Loss caused by or relating to a Pre-existing Condition is not covered for the first [6 – 12] months after the Certificate Effective Date of each Covered Person.

EXCLUSIONS:

No coverage shall be provided and no benefits will be paid for any loss resulting in whole or in part from, or contributed to, or as a natural and probable consequence of any of the following excluded risks:

1. Suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or any act of auto-eroticism, while sane or insane;

2. Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Covered Person is:
   a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
   b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   c. riding as a passenger in an aircraft owned, leased or operated by the Covered Person's employer;

3. Declared or undeclared war, or any act of declared or undeclared war;

4. Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Covered Person is not covered due to his or her active duty status will be refunded. Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);

5. The Covered Person’s being intoxicated (defined as blood alcohol concentration equal to or in excess of .08 gms/dl blood alcohol). This applies whether or not the Covered Person is charged with any violation in connection with a loss and there is no need to prove a loss was caused, contributed to, or resulted from the excessive blood alcohol concentration;

6. The Covered Person’s: 1) voluntary use of illegal drugs; 2) the intentional taking of over the counter medication not in accordance with recommended dosage and warning instructions; and 3) intentional misuse of prescription drugs;

7. The Covered Person’s commission of or attempt to commit a felony;

8. The Covered Person being engaged in an illegal occupation;

9. Services and supplies which are not prescribed by a Physician as Medically Necessary to treat a covered loss.

10. Services and supplies which are received without charge or legal obligation to pay or would not normally be paid in the absence of insurance;

11. Services and supplies which are received outside of the United States of America, it’s possessions and territories;

12. Dental care or treatment unless due to an Injury to a sound and natural tooth;

13. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace, or remove breast implants; however, this Exception does not apply when surgery is required:
    a) To repair a birth defect of a child born to the Insured and continuously covered under the Policy from birth; or
    b) For reconstructive surgery following a covered mastectomy;

14. Any covered loss that is covered under any state or federal Worker's Compensation , Employer's Liability law or similar law;
15. Any mental or nervous disorders or alcoholism or substance abuse;
16. Any procedure for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices;
17. Pregnancy or maternity. Complications of Pregnancy are not excluded;
18. Participating in any organized sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event;
19. Care in a custodial institution, domiciliary care or rest cures;
20. Weight reduction or treatment of obesity, including exogenous, endogenous or morbid obesity;
21. Diagnosis or treatment (including surgery) of sexual dysfunctional disorders or inadequacy, or transsexual surgery; or
22. Routine newborn care.

PREMIUM

PREMIUMS
The Company provides insurance in return for premium payments in the manner described in the Certificate Schedule of Benefits. The Company may change the required premiums due by giving the Insured at least 60 days advance written notice. The Company may also change the required premiums at any time when any change affecting rates is made in this Policy. Premiums for coverage may change if a change in benefits occurs or dependents are added or deleted.

GRACE PERIOD
A grace period may apply to any premium payments made in any mode other than a single premium. Premium payments after the initial premium payment may be paid within the grace period. The grace period will last for [31-60] days after the due date of the premium payment. During the Grace Period, the coverage will remain in force. However, the Company is not obligated to pay any claims incurred during the Grace Period until the premium due is received. If premium payments are not made by the end of the grace period, the coverage will immediately cease to be in force.

No Grace Period will be provided if the Company receives notice to terminate the Covered Person's coverage under the Policy prior to a premium due date.

UNPAID PREMIUM
Any due and unpaid premium may be deducted from any benefits then payable.

PREMIUM REFUND AT DEATH
If a Covered Person's coverage terminates due to death, the Company will refund the pro rata unearned portion of any premium paid for such Covered Person.

MISSTATEMENT OF AGE
If premiums for the Covered Person are based on age and the Covered Person's age has been misstated, there will be an adjustment of premiums based on his or her true age. If the benefits for which the Covered Person is insured are based on age and the Covered Person's age has been misstated, there will be an adjustment of said benefit based on his or her true age. The Company may require satisfactory proof of age before paying any claim.

CLAIM PROVISIONS

NOTICE OF CLAIM
The Insured must give the Company written notice of a claim. It should be given within 60 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by the Insured or on behalf of the Insured to Us at our Home Office, or to any authorized agent of the Company, with information sufficient to identify the Covered Person, will be deemed notice to the Company.

CLAIM FORMS
The Company will send the Insured a claim form when a notice of claim is received. If the form is not furnished within 15 days from the time the Insured gives notice, the Insured may fulfill the proof of loss requirements by sending written proof covering the occurrence, the character and the extent of the loss for which claim is made within the time set in Proof of Loss.

PROOF OF LOSS
The Insured must give the Company written proof of loss within 90 days after such loss. If it is not reasonably possible to do so, the Company will not reduce or deny the Insured's claim for being late if proof is given as soon as reasonably possible. It must, however, be given within 15 months from the date of loss, unless the Insured is not legally capable.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS
If any benefit of this Policy is payable to the estate of the Insured, or to an Insured who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Insured who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

ASSIGNMENT
An Insured may assign all of his or her rights, privileges and benefits under this Policy without anyone's consent. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of this Policy.

PHYSICAL EXAMINATIONS AND AUTOPSY
The Company may have a Covered Person examined at its own expense as often as it may reasonably require while their claim is pending under the Policy and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS
No action at law or in equity shall be brought to recover under this Policy for at least 60 days after the Insured has given the Company written proof of loss in accordance with the requirements of this Policy. The Insured cannot start such action more than 3 years after the date proof of loss is required to be furnished.

RIGHT OF RECOVERY
When an overpayment has been made by Us, We will have the right to: a) recover that overpayment from the person to whom or on whose behalf it was made; or b) offset the amount of that overpayment from a future claim payment.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES
The Policy, the Application(s), the Riders (if any), and any attached papers make up the entire contract between the Policyholder and the Company.

In the absence of fraud, all statements made by the Policyholder or the Insured will be considered representations and not warranties. No written statement made by the Policyholder or Insured will be used in any contest unless a copy of the statement is furnished to the Policyholder or the Insured or his or her personal representative.

No change in this Policy will be valid until approved by an executive officer of the Company. The approval must be attached to this Policy. No agent may change the Policy or waive any of it's provisions.

The Company may amend or change this Policy by written agreement with the Policyholder. We may amend or change this Policy at any time, without the consent of the Policyholder, the Insured, any Covered Person if required by law. Any amendment will be without prejudice to any charge incurred prior to the effective date of the change.

TIME LIMIT ON CERTAIN DEFENSES
After 2 years from the Policy Effective Date or the Certificate Effective Date, no misstatements, except fraudulent misstatements, made by the Policyholder or the Insured in the application for coverage will be used to void this Policy or a Certificate after the expiration of the two-year period.

A claim for loss incurred beginning [6-12] months after a Covered Person's Certificate Effective Date will not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage.

CONFORMITY WITH STATE STATUTES
Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which this Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

REINSTATEMENT
Coverage terminates if an Insured does not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under an Insured's Certificate.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of this Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify the Insured in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:
1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after a Covered Person's date of reinstatement.

In all other respects, a Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which an Insured has not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

CLERICAL ERROR
Clerical error, whether by the Insured or the Company, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect nor extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in this Policy.

INDIVIDUAL CERTIFICATES
An individual Certificate of Insurance which sets forth a description of the benefits and terms that apply to such benefits and coverages will be delivered to each Insured.

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Standard Life and Accident Insurance Company

Home Office: One Moody Plaza, Galveston, Texas, 77550
Toll-Free Telephone Number: 1-888-350-1488
(A Stock Insurance Company hereafter referred to as "Standard Life", "We", "Us", "Our" or "the Company")

GROUP HOSPITAL INDEMNITY SUPPLEMENTAL INSURANCE CERTIFICATE OF COVERAGE

This is the Insured's Certificate of Coverage (hereafter Certificate) while insured under the Group Policy (hereafter Policy). It explains the rights and benefits that are determined by the Policy. A copy of the Policy is kept at the principal office of the Policyholder. A Covered Person may inspect it during regular business hours. **READ THE CERTIFICATE CAREFULLY!**

CONSIDERATION. The coverage is issued in consideration of the statements made in the Enrollment Application and payment of the Initial Premium. Coverage is not provided until the first full premium is paid. The first premium pays for the Initial Term of coverage. The Initial Term of coverage begins at 12:01 a.m. on the Effective Date shown on the Certificate Schedule.

TERMINATION. The coverage may be terminated by the Company for reasons stated in the Termination provision.

PREMIUMS. The Company may change premiums for coverage. Premiums may be changed and are due as stated in the **Premiums** provision.

30 DAY RIGHT TO EXAMINE CERTIFICATE. Within 30 days after the Insured receives the Certificate, it may be returned in person or by regular mail to the Company, its agency office or the agent who sold it to the Insured for any reason. The Company will return the premium to the payee. Then the Insured and the Company will be in the same position as if a Certificate had never been issued.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If any Covered Person is eligible for Medicare, such person should review the "Guide to Health Insurance for People with Medicare" available from the Company.

Signed for Us on the Certificate Effective Date.

Secretary

President

NOTICE TO BUYER:
THIS CERTIFICATE ONLY PROVIDES LIMITED BENEFITS. IT IS NOT A MAJOR MEDICAL OR COMPREHENSIVE HEALTHCARE POLICY. IT IS NOT DESIGNED TO COVER ALL OF YOUR MEDICAL EXPENSES. PLEASE READ CAREFULLY!

NO BENEFITS ARE PAYABLE FOR SICKNESS DURING THE FIRST 30 DAYS FOLLOWING A COVERED PERSON'S EFFECTIVE DATE.

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CERTIFICATE SCHEDULE OF BENEFITS

POLICYHOLDER: [United Service Associaiton For Health Care]

INSURED: [John Doe]

CERTIFICATE NUMBER: [SLA012345]

TYPE: [FAMILY]

COVERED PERSON(S):
[John Doe]
[Baby Doe]

CERTIFICATE EFFECTIVE DATE:
[July 1, 2013]

STATE OF ISSUE: [STATE}

INSURED"S AGE AT ISSUE: [32]

HOSPITAL BENEFIT:

[Hospital Admission Benefit: .....[$0 – $10,000]]

Hospital Confinement Benefit:

[Elimination Period
Sickness……[0][3][7] Days]

Daily Hospital Confinement Benefit……..……[$50 - $2,000] Per Day

Maximum Hospital Confinement Benefit Period ……...[10][15][30][60][90][365] Days

Intensive Care Unit Benefit:

Daily Intensive Care Unit Benefit .....[$50 – $2,000] Per Day

Maximum Intensive Care Unit Benefit Period ..... [10][15][20][30] Days

CONTINUOUS CARE BENEFIT:

Daily Benefit..... [$25 – $500] Per Day

Maximum Continuous Care Benefit Period..... [the length of the preceding Period of Confinement in a Hospital not to exceed [10][15][30] days of care]

EMERGENCY MEDICAL SERVICES BENEFIT:

Emergency Medical Services Benefit…….. $25 Per Visit
(Payable Once Per Year Per Covered Person)

PREMIUM RATES:

Total Annual Premium: .....……[$xxx.00]

Initial Term:…… [Monthly, Quarterly, Semi-Annual, Annual, Monthly Draft]

Initial Premium……[$xxx.00]

[INTENTIONALLY LEFT BLANK]

DEFINITIONS-GENERAL

Accident or Accidental means an act or event which is unforeseen, unexpected and unanticipated, definite as to time and place, which:
1. causes Injury to one or more Covered Persons; and
2. occurs while coverage is in effect for the Covered Person.

Age means a Covered Person's Age as of his/her last birthday.

Certificate Effective Date means the date insurance begins for a Covered Person under the Policy.

Complications of Pregnancy means:
1. conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but does not include false labor, pre-term or premature labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Covered Person means an Insured, an Insured's spouse, or Dependent children:
1. whom the Insured has elected to cover under the Policy ;
2. for whom premium has been paid; and
3. listed as a Covered Person in the Certificate Schedule of Benefits.

The Insured must be listed as a Covered Person in order to be covered under the Policy.

Dependent means an Insured's family as follows:
1. A lawful Spouse*, if not legally separated or divorced;
2. Unmarried children (whether natural, adopted or stepchildren) under the limiting age of 26; or
3. Unmarried children for whom an Insured is required to provide insurance under a medical support order or an order enforceable by a court.

*The term "Spouse" as used throughout this Certificate will also means an Insured's legal Domestic Partner.

Domestic Partner means a person with whom an Insured maintains a committed relationship and with whom an Insured has registered as domestic partners by executing a declaration of domestic partnership filed with the with the appropriate state agency. Each partner must:
1. Be at least 18 years old and competent to contract;
2. Be the sole domestic partner of the other person; and
3. Not be married.

[Elimination Period means the consecutive number of days the Covered Person is confined as an Inpatient before a benefit is payable.]

Enrollment Application means the form(s) that the Insured (and the Insured's spouse, if any) signed to apply for coverage under the Policy. It also includes any other document approved by the Company that the Insured uses to apply for or change coverage under the Policy.

Home Health Care means a program of professional, paraprofessional or skilled care provided through a Home Health Care Agency to a Covered Person in his or her home. This care is limited to the following:
1. Nursing services provided by a:
   (a) registered nurse;
   (b) licensed practical nurse;
   (c) licensed vocational nurse; or
   (d) a licensed public health nurse;
2. Physical therapy;
3. Speech therapy;
4. Respiratory therapy; or
5. Occupational therapy.

Home Health Care Agency means an agency or organization which provides Home Health Care services, and:
1. Is licensed or certified, if required by the jurisdiction in which it is located; or accredited by:
   (a) the National Home Caring Council, a Division of the Foundation for Hospice and Home Care;
   (b) the Joint Commission Accreditation of Health Care Organizations; or
   (c) the National League for Nursing;
2. Is supervised by a qualified professional such as a registered nurse or a licensed social worker;
3. Whose employees receive appropriate specialized training; and
4. Keeps clinical records, including Physician's orders where appropriate, on all patients.

Hospice means a licensed agency, organization, or unit that provides a centrally administered and autonomous continuum of palliative and supportive care to terminally ill persons and their families. The care must be directed and coordinated by the Hospice organization and received primarily in the patient's home, or on an outpatient or short-term inpatient basis in a Hospice unit.

Hospital means a legally operated institution licensed by the state in which it is located that maintains and uses a laboratory, X-ray equipment and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises.

The term "Hospital" does not include any institution or part thereof used as a Rehabilitation Unit or Rehabilitation Facility; a Hospice unit, including any bed designated as a Hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended-care facility; a Skilled Nursing Facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

Immediate Family Member means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild.)

Injury or Injuries means Accidental bodily Injury sustained by a Covered Person in an Accident that:
1. is the direct cause of the condition for which benefits are provided,
2. is independent of disease or bodily infirmity or any other cause, and
3. occurs while this insurance is in force.

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

Inpatient means confined overnight as a registered bed patient in a Hospital where at least one day's room and board is charged. Inpatient does not include a Covered Person's treatment in an ambulatory surgical center, emergency room, or an observation room. The confinement must be Medically Necessary.

Insured means the Association member described in the Enrollment Application, any successor thereof, or, in the case of the death of the Association Member, any person thereafter named to assume ownership privileges under the Policy. Such person, regardless of title, has exclusive ownership privileges under the Policy. These privileges include, but are not limited to, his/her right to change coverage under the Policy for themselves or any Covered Person. The Insured must be listed as a Covered Person in the Certificate Schedule of Benefits and appropriate premium paid in order to be covered under the Policy.

Intensive Care Unit (ICU) means a specifically designated unit of the Hospital that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The ICU must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the ICU on a full-time basis. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (1) Intensive Care Units, (2) Cardiac Intensive Care Units, and (3) Infant (Neonatal) Intensive Care Units.

Medically Necessary means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of Injury or Sickness. We do not consider a service or supply as Medically Necessary if:

1. it is provided only as a convenience to the Covered Person or provider;
2. it is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. it is experimental or investigational.

The fact that a Doctor may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Outpatient means the Covered Person is not confined in a Hospital.

Period of Confinement means a time period of continuous confinement as an Inpatient in a Hospital. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated Injury or Sickness or the confinements are separated by [30-180] days.

Physician means a licensed practitioner of the healing arts acting within the scope of his or her license who is not:

1. the Covered Person; or
2. an Immediate Family Member.

Policyholder means the entity to which the group Policy is issued.

Pre-existing Condition means a condition not otherwise excluded by name or specific description:

1. for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Physician within [6 – 12] months before the Certificate Effective Date; or
2. that would have caused a reasonable person to seek medical diagnosis or treatment within [6 – 12] months before the Certificate Effective Date.

Rehabilitation Facility means an institution whose primary purpose is to provide restorative therapy to disabled persons. Such facility must be licensed as such in the state in which it operates. "Rehabilitation Facility" does not include places for custodial care or places for confinement of drug addicts or alcoholics.

Rehabilitation Unit means a unit of a Hospital providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Sickness means Sickness or disease which begins while coverage is in force under the Policy for the Covered Person. Sickness does not include normal pregnancy, but does include Complications of Pregnancy.

All related conditions and recurring symptoms of Sickness will be considered one Sickness.

Skilled Nursing Facility means a lawfully operating institution or a distinct part thereof. Such facility must be engaged mainly in providing skilled nursing care and treatment for people convalescing from an Injury or Sickness. It must: (1) have organized facilities for medical services; (2) provide 24 hour a day nursing services under the full-time supervision of a Physician or a registered nurse; (3) have available the services of a Physician at all times; (4) maintain daily clinical records on each patient; and (5) provide appropriate methods for dispensing and administering drugs and medicines.

A Skilled Nursing Facility shall include the following facilities that are operating within the scope of their lawful licenses: (1) a rehabilitation center; (2) a transitional care unit; (3) an intermediate nursing facility; (4) an extended care facility; and (5) a nursing home.

A Skilled Nursing Facility does not mean a home or facility, or part of home or facility, that is used primarily for: (1) rest; (2) the aged; (3) alcoholics or drug addicts; (4) mental illness or disorders; (5) custodial care; or (6) educational care.

Waiting Period means a consecutive 30 day period of time starting with the Certificate Effective Date for each Covered Person during which no benefits are payable for a Sickness.

You, Your or Yours means the Insured named on the Certificate Schedule of Benefits.

ELIGIBILITY AND EFFECTIVE DATES

The Insured's Certificate Schedule of Benefits shows Covered Persons initially covered under the Policy. The insurance for a Covered Person will take effect on the Certificate Effective Date assigned by Us and shown in the Insured's Certificate Schedule of Benefits.

ON THE CERTIFICATE EFFECTIVE DATE

The Insured's Certificate Schedule of Benefits shows Covered Persons initially covered under the Policy. The insurance for a Covered Person will take effect on the Certificate Effective Date assigned by Us and shown in the Insured's Certificate Schedule of Benefits.

AFTER THE CERTIFICATE EFFECTIVE DATE

The Insured may apply for coverage for eligible dependents after the Certificate Effective Date. The Insured must complete a new application and submit evidence of insurability if requested by Us for the eligible dependent. Acceptance for coverage will be in accordance with Our rules in effect on any application date. The insurance for a Covered Person will take effect on the Certificate Effective Date assigned by Us.

No Insured may be eligible for insurance under the Policy as both an Insured and as a Spouse or Dependent Child at the same time. If an Insured and Spouse are both eligible to be covered as an Insured, one but not both, is eligible to cover the Dependent Children. The other Spouse may elect single coverage only.

NEWBORN CHILDREN

The Insured's newborn child is automatically covered from the moment of birth until such child is 31 days old. Coverage for newborns shall be the same as for other covered Dependents under Your coverage. If the Insured does not have other covered Dependents and wants uninterrupted coverage, the Insured will have the option to add Dependent child coverage to the Insured's coverage. The Insured must notify the Company in writing within 31 days of such birth and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 31 day period.

ADOPTED CHILDREN

An adopted child is automatically covered for the first 31 days from the date of placement for the purpose of adoption by the Insured or the date of the entry of an order granting the Insured custody of the child. Coverage for such child will be the same as for other covered Dependents under Your coverage. If the Insured does not have other covered Dependents and wants uninterrupted coverage, the Insured will have the option to add Dependent child coverage to the Insured's coverage. The Insured must notify the Company in writing within 31 days of the date of placement or the date of the entry and pay the required additional premium (if any), in order to have coverage for the adopted child continue beyond such 31 day period.

Coverage for a child that is placed with You for adoption will continue in accordance with the provisions of the Policy, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

TERMINATION AND CONTINUATION

Coverage under the Policy for a Covered Person ends on the earliest of:
1. the date the Policy is terminated by the Company or the Policyholder;
2. the premium due date if premiums are not paid when due, subject to the Grace Period;
3. the date a Covered Person performs an act or practice that constitutes fraud;
4. the date the Insured requests, in writing, that the coverage be terminated; or
5. the date the Dependent does not meet the definition of a Dependent under the Policy.

If coverage is non-renewed under number 1 by the Policyholder, the Policyholder is responsible for providing each Insured notice of such termination. If coverage is non-renewed under number 1 by the Company, We will provide at least 60 days advance written notice to the Insured.

If We refuse to renew coverage due to non-payment of premiums, We will provide 30 days written notice of termination of coverage prior to the non-renewal date in accordance with the Grace Period.

At the time of coverage renewal, We may modify coverage under the Policy. However, the modification must be consistent with State law and effective on a uniform basis among all individuals that We cover under the Policy.

Subject to the conditions listed above, We cannot refuse to renew coverage:
1. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
2. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

Termination of coverage will not affect a claim for a covered loss that occurred while the coverage was in force under the Policy.

CONTINUATION OF AN INCAPACITATED CHILD

If a Dependent child reaches the limiting age as defined in the definition of Dependent and continues to be both: (a) incapable of self-sustaining employment by reason of mental incapacity or physical handicap; and (b) remains dependent upon the Insured for support and maintenance, coverage for such child will continue while the coverage is in force and so long as such incapacity continues and the applicable premium is paid.

Satisfactory proof must be submitted to Us by the Insured within 31 days of such termination date. During the next two years we may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year. The premium for such child's continued coverage will be the same as for an adult of like age and gender.

CONTINUATION PROVISION

The following Covered Persons are eligible to continue coverage under the Policy if coverage is terminated for reasons other than non-payment of premium or fraud:
1. a Spouse and covered Dependent children in the event of the death of the Insured;
2. a Spouse in the event of legal dissolution of the marriage.

In the event of the Insured's death when there is not a covered Spouse, coverage ends for all Covered Persons on the date of the Insured's death.

To continue insurance under the Policy, the Spouse must:
1. become a member of the Association to which the Policy was issued;
2. submit a request to Us within 31 days after coverage under this Certificate terminates; and
3. timely pay the required premium.

Premium rates for coverage under this continuation will be based on the Covered Person's class at the time of election. If the Covered Person does not elect to continue insurance within 31 days after the coverage ends, coverage may not be elected under this provision at a later date.

Coverage under the new Certificate will begin for a Covered Person on the date coverage terminates under this Certificate. Any benefits paid under this Certificate will be deducted from benefits payable under the new Certificate. Benefits paid under this Certificate, together with benefits payable under any new Certificate that may be issued, will not exceed those that would have been payable had the Covered Person's insurance under this Certificate remained in force and effect.

BENEFITS AND COVERAGES

Benefits described below are payable as stated in the Certificate Schedule of Benefits when a Covered Person incurs charges for Medically Necessary treatment while coverage is in force, subject to any applicable terms, exclusions or limitations. Benefits for Sickness are subject to the Waiting Period.

HOSPITAL BENEFITS

[Hospital Admission Benefit:

If a Covered Person is admitted as an Inpatient in a Hospital for treatment of Sickness or Injury, the Company will pay the Hospital Admission Benefit shown in the Certificate Schedule of Benefits.

The Hospital Admission Benefit is payable once during each Period of Confinement.]

Hospital Confinement Benefit:

If a Covered Person is confined as an Inpatient in a Hospital for treatment of Sickness or Injury, the Company will pay the Daily Hospital Confinement Benefit shown in the Certificate Schedule of Benefits for each day that a Covered Person is charged for room and board as Inpatient care.

The Daily Hospital Confinement Benefit is payable up to the Maximum Hospital Confinement Benefit Period shown in the Schedule of Benefits for each Period of Confinement.

No benefits are payable during the Waiting Period [or Elimination Period] for Sickness. [The Elimination Period does not run concurrently with the Waiting Period and must be satisfied after the Waiting Period has been met.]

We do not provide benefits for treatment received in an emergency room, any Outpatient setting, skilled nursing facility, rehabilitation facility, rehabilitation Unit, hospice or any other facility other than a Hospital.

Intensive Care Unit Benefit:

While a Covered Person is receiving the Hospital Confinement Benefit due under the Policy, the Company will pay an additional benefit equal to the Daily Intensive Care Unit Benefit shown in the Certificate Schedule of Benefits for each day a Covered Person is confined in and charged for an Intensive Care Unit.

The Daily Intensive Care Unit Benefit is payable for up to the Maximum Intensive Care Unit Benefit Period shown in the Certificate Schedule of Benefits for each Period of Confinement.

CONTINUOUS CARE BENEFIT

If a Covered Person is receiving Inpatient care in a Hospital and upon discharge requires Continuous Care, We will pay the Daily Benefit for each day up to the Maximum Continuous Care Benefit Period shown in the Certificate Schedule of Benefits.

Continuous Care means care received in a Skilled Nursing Facility, Rehabilitation Facility, Rehabilitation Unit or Home Health Care or Hospice care in connection with the condition for which he or she was hospitalized.

The following conditions must be met before Continuous Care benefits are payable:

1. Continuous Care must begin within 7 days following discharge from Inpatient care in a Hospital;
2. Continuous Care must be for the same Accident or Sickness for which the Covered Person was hospitalized;
3. The Continuous Care must be prescribed by a Physician and must be Medically Necessary for the care and treatment of the Covered Person's condition;
4. Home Health Care services must be performed by a Home Health Care Agency. Home Health Care services cannot be performed by a person who lives with the Covered Person or by the Covered Person's Immediate Family Member;
5. Hospice care services require: (a) a written statement from the attending Physician that the Covered Person has a life expectancy of six (6) months or less, and (b) a written statement from the Hospice certifying the days that services were provided.

The Daily Benefit is payable once per day regardless of how many Continuous Care services are provided on that day. Benefits are not payable if the Covered Person is Hospital confined on an Inpatient basis.

EMERGENCY MEDICAL SERVICES BENEFIT

If a Covered Person receives Emergency Medical Services for the treatment of a Medical Emergency, the Company will pay the Emergency Medical Services Benefit as shown in the Certificate Schedule of Benefits.

As used in this provision:

“Ancillary Services" means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

“Emergency Medical Services” means:

1. Health care services furnished in the emergency department of a Hospital for the treatment of a Medical Emergency;
2. Ancillary Services routinely available to the emergency department of a Hospital for the treatment of a Medical Emergency; and
3. Emergency Medical Services transportation (air or ground ambulance).

"Medical Emergency" means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

EXCLUSIONS AND LIMITATIONS

WAITING PERIOD FOR SICKNESS:

Loss caused by or relating to Sickness will not be covered for this first 30 days after the Certificate Effective Date of each Covered Person.

PRE-EXISTING CONDITION LIMITATION:

Loss caused by or relating to a Pre-existing Condition is not covered for the first [6 – 12] months after the Certificate Effective Date of each Covered Person.

EXCLUSIONS:

No coverage shall be provided and no benefits will be paid for any loss resulting in whole or in part from, or contributed to, or as a natural and probable consequence of any of the following excluded risks:

1. Suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or any act of auto-eroticism, while sane or insane;

2. Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Covered Person is:
   a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
   b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   c. riding as a passenger in an aircraft owned, leased or operated by the Covered Person's employer;

3. Declared or undeclared war, or any act of declared or undeclared war;

4. Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Covered Person is not covered due to his or her active duty status will be refunded. Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);

5. The Covered Person's being intoxicated (defined as blood alcohol concentration equal to or in excess of .08 gms/dl blood alcohol). This applies whether or not the Covered Person is charged with any violation in connection with a loss and there is no need to prove a loss was caused, contributed to, or resulted from the excessive blood alcohol concentration;

6. The Covered Person's: 1) voluntary use of illegal drugs; 2) the intentional taking of over the counter medication not in accordance with recommended dosage and warning instructions; and 3) intentional misuse of prescription drugs;

7. The Covered Person's commission of or attempt to commit a felony;

8. The Covered Person being engaged in an illegal occupation;

9. Services and supplies which are not prescribed by a Physician as Medically Necessary to treat a covered loss.

10. Services and supplies which are received without charge or legal obligation to pay or would not normally be paid in the absence of insurance;

11. Services and supplies which are received outside of the United States of America, it's possessions and territories;

12. Dental care or treatment unless due to an Injury to a sound and natural tooth;

13. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace, or remove breast implants; however, this Exception does not apply when surgery is required:
    a) To repair a birth defect of a child born to the Insured and continuously covered under the Policy from birth; or
    b) For reconstructive surgery following a covered mastectomy;

14. Any covered loss that is covered under any state or federal Worker's Compensation , Employer's Liability law or similar law;
15. Any mental or nervous disorders or alcoholism or substance abuse;
16. Any procedure for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices;
17. Pregnancy or maternity. Complications of Pregnancy are not excluded;
18. Participating in any organized sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event;
19. Care in a custodial institution, domiciliary care or rest cures;
20. Weight reduction or treatment of obesity, including exogenous, endogenous or morbid obesity;
21. Diagnosis or treatment (including surgery) of sexual dysfunctional disorders or inadequacy, or transsexual surgery; or
22. Routine newborn care.

PREMIUM

PREMIUMS
The Company provides insurance in return for premium payments in the manner described in the Certificate Schedule of Benefits. The Company may change the required premiums due by giving the Insured at least 60 days advance written notice. The Company may also change the required premiums at any time when any change affecting rates is made in the Policy. Premiums for coverage may change if a change in benefits occurs or dependents are added or deleted.

GRACE PERIOD
A grace period may apply to any premium payments made in any mode other than a single premium. Premium payments after the initial premium payment may be paid within the grace period. The grace period will last for [31-60] days after the due date of the premium payment. During the Grace Period, the coverage will remain in force. However, the Company is not obligated to pay any claims incurred during the Grace Period until the premium due is received. If premium payments are not made by the end of the grace period, the coverage will immediately cease to be in force.

No Grace Period will be provided if the Company receives notice to terminate the Covered Person's coverage under the Policy prior to a premium due date.

UNPAID PREMIUM
Any due and unpaid premium may be deducted from any benefits then payable.

PREMIUM REFUND AT DEATH
If a Covered Person's coverage terminates due to death, the Company will refund the pro rata unearned portion of any premium paid for such Covered Person.

MISSTATEMENT OF AGE
If premiums for the Covered Person are based on age and the Covered Person's age has been misstated, there will be an adjustment of premiums based on his or her true age. If the benefits for which the Covered Person is insured are based on age and the Covered Person's age has been misstated, there will be an adjustment of said benefit based on his or her true age. The Company may require satisfactory proof of age before paying any claim.

CLAIM PROVISIONS

NOTICE OF CLAIM
The Insured must give the Company written notice of a claim. It should be given within 60 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by the Insured or on behalf of the Insured to Us at our Home Office, or to any authorized agent of the Company, with information sufficient to identify the Covered Person, will be deemed notice to the Company.

CLAIM FORMS
The Company will send the Insured a claim form when a notice of claim is received. If the form is not furnished within 15 days from the time the Insured gives notice, the Insured may fulfill the proof of loss requirements by sending written proof covering the occurrence, the character and the extent of the loss for which claim is made within the time set in Proof of Loss.

PROOF OF LOSS
The Insured must give the Company written proof of loss within 90 days after such loss. If it is not reasonably possible to do so, the Company will not reduce or deny the Insured's claim for being late if proof is given as soon as reasonably possible. It must, however, be given within 15 months from the date of loss, unless the Insured is not legally capable.

TIME OF PAYMENT OF CLAIMS
Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS
If any benefit of the Policy is payable to the estate of the Insured, or to an Insured who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Insured who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

ASSIGNMENT
An Insured may assign all of his or her rights, privileges and benefits under the Policy without anyone's consent. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

PHYSICAL EXAMINATIONS AND AUTOPSY
The Company may have a Covered Person examined at its own expense as often as it may reasonably require while their claim is pending under the Policy and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS
No action at law or in equity shall be brought to recover under the Policy for at least 60 days after the Insured has given the Company written proof of loss in accordance with the requirements of the Policy. The Insured cannot start such action more than 3 years after the date proof of loss is required to be furnished.

RIGHT OF RECOVERY
When an overpayment has been made by Us, We will have the right to: a) recover that overpayment from the person to whom or on whose behalf it was made; or b) offset the amount of that overpayment from a future claim payment.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES
The Policy, the Application(s), the Riders (if any), and any attached papers make up the entire contract between the Policyholder and the Company.

In the absence of fraud, all statements made by the Insured will be considered representations and not warranties. No written statement made by the Insured will be used in any contest unless a copy of the statement is furnished to the Insured or his or her personal representative.

No change in the Policy will be valid until approved by an executive officer of the Company. The approval must be attached to the Policy. No agent may change the Policy or waive any of it's provisions.

The Company may amend or change the Policy by written agreement with the Policyholder. We may amend or change the Policy at any time, without the consent of the Policyholder, the Insured or any Covered Person, if required by law. Any amendment will be without prejudice to any charge incurred prior to the effective date of the change.

TIME LIMIT ON CERTAIN DEFENSES
After 2 years from the Certificate Effective Date, no misstatements, except fraudulent misstatements, made by the Insured in the application for coverage will be used to void the coverage after the expiration of the two-year period.

A claim for loss incurred beginning [6-12] months after a Covered Person's Certificate Effective Date will not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage.

CONFORMITY WITH STATE STATUTES
Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

REINSTATEMENT
Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under the Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of the Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:
1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

CLERICAL ERROR
Clerical error, whether by the Insured or the Company, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect nor extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in the Policy.

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Home Office: One Moody Plaza, Galveston, Texas 77550
Toll-Free Telephone Number: 1-888-350-1488
A Stock Company hereafter referred to as "Standard Life", "We", "us", "our" or "the Company"

MASTER APPLICATION

Request is hereby made to Standard Life and Accident Insurance Company for group insurance as indicated below:

Applicant's Name: United Service Association for Health Care

Insurance Applied For: Group Hospital Indemnity

Proposed Effective Date: May 1, 2013

This program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Standard Life and Accident Insurance Company. Any statements in this application are deemed to be representations and not warranties. The terms of the policy are hereby accepted and approved and take effect on the effective date specified in the Policy. It is agreed that this application supersedes any previous application for this Policy.

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any Insurer, makes any claim for the proceeds of an insurance Policy containing any false, incomplete or misleading information may be guilty of a felony.

Signature of Authorized Representative

4/12/2013
Date

President and Executive Director
Title

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

ENROLLMENT FORM FOR GROUP HOSPITAL INDEMNITY INSURANCE – ASSOCIATION MEMBER

SUPPLEMENTAL INSURANCE

THIS IS A SUPPLEMENTAL INSURANCE POLICY THAT WILL ONLY BE ISSUED IF YOU HAVE AN EXISTING MAJOR MEDICAL OR COMPREHENSIVE MEDICAL PLAN.

Group Policy Holder _____ Requested Effective Date _____

Enrollee Name _____

Enrollee Address _____

City _____ State _____ Zip _____

Social Security Number _____ Daytime Phone Number _____

Gender ☐ Male ☐ Female D.O.B. _____ E-mail Address _____

PLAN OPTIONS

Plan Selection: _____

Coverage: ☐ Member Only ☐ Member & Spouse ☐ Member & Child(ren) ☐ Family

SPOUSE AND DEPENDENT INFORMATION (If other than Member Only coverage applied for.)

Dependent Name	Date of Birth	Social Security Number
(Spouse)		

Do you have a comprehensive medical policy?..... ☐ Yes ☐ No
(If you answer NO, you are not eligible for this supplemental policy).
Do you understand that this is a supplemental only policy and that
the benefits provided under this policy are limited?..... ☐ Yes ☐ No

FRAUD WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the Applicant.

Voice/Electronic Signature

_____ _____
Enrollee's Signature Date

SERFF Tracking #:	*ANTX-129000350*	***State Tracking #:***		***Company Tracking #:***	*USAHC RATE*

State:	*District of Columbia*	***Filing Company:***	*Standard Life and Accident Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*GR ASSOC HOSPITAL INEMNITY-RATES*		
Project Name/Number:	*GR ASSOC HOSPITAL INEMNITY-RATES/GR ASSOC HOSPITAL INEMNITY-RATES*		

Supporting Document Schedules

Satisfied - Item:	Cover Letter All Filings
Comments:	
Attachment(s):	COVER LETTER INFORMATION.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Certificate of Authority to File
Bypass Reason:	n/a
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	Actuarial Memo/Rates
Attachment(s):	DC ActMemo 50% LR.pdf USAHC Exhibits DC.pdf USAHC Exhibits II.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Justification
Bypass Reason:	Actuary's certification is contained in the attached actuarial memorandum.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Loss Ratio Analysis (P&C)
Bypass Reason:	N/A - Rates are being filed on a new supplemental (limited benefit) product.
Attachment(s):	
Item Status:	

SERFF Tracking #:	*ANTX-129000350*	***State Tracking #:***		***Company Tracking #:***	*USAHC RATE*

State:	*District of Columbia*	***Filing Company:***	*Standard Life and Accident Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*GR ASSOC HOSPITAL INEMNITY-RATES*		
Project Name/Number:	*GR ASSOC HOSPITAL INEMNITY-RATES/GR ASSOC HOSPITAL INEMNITY-RATES*		

Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)
Bypass Reason:	N/A - Rates are being filed on a new supplemental (limited benefit) product.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum and Certifications
Bypass Reason:	N/A These are rates on a new supplemental (limited benefit) product
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Unified Rate Review Template
Bypass Reason:	n/a We are filing rates on a new product.
Attachment(s):	
Item Status:	
Status Date:	

COVER LETTER INFORMATION

Rate Filing – ANTX-129000350

A.Unique Company Filing Number (assigned by Company): USAHC Rate

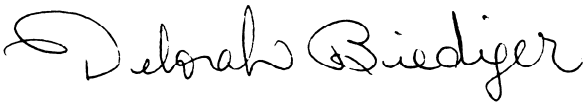
B.Proposed Effective Date – Upon Approval

C.Purpose of Filing – This is the rate filing for the new product which forms have been submitted to the Department under SERFF tracking number ANTX- 128998969.

D.Indication if Initial Filing - Yes, this is the initial filing of the forms and the rates

E.Indication if no DC Policyholders - The proposed Policyholder is a group association incorporated in the District of Columbia

F.Overall Premium Impact of Filing on DC Policyholders – This is not a rate increase on an in force product.



Deborah Biediger

Compliance Analyst

April 24, 2013

Standard Life and Accident Insurance Company

Actuarial Memorandum

Group Accident and Sickness Insurance Policy Form SL-USAHC - P

1. Scope & Purpose

This Actuarial Memorandum describes the benefits provided in this new policy form. This memorandum supports the rates being filed. This is a new form. This memorandum is not intended to be used for any other purpose.

2. Benefit Description

This section contains a brief description of the benefits provided by the policy. A detailed description of the benefits and limitations are identified in the policy. This policy pays the benefits for a qualifying event caused by a covered accident or sickness. A loss caused by or associated with sickness will not be covered for the first 30 days following the effective date. Mental or nervous disorders, alcoholism or substance abuse, and maternity or pregnancy will not be covered under this policy.

Hospital Admission Benefit: Pays a benefit if an insured person is admitted in a hospital as a result of injury or sickness.

Hospital Confinement Benefit: Pays a daily hospital confinement benefit if an insured person is confined to a hospital as a result of injury or sickness. No benefits are payable during the elimination period or waiting period for sickness.

Intensive Care Unit Benefit: Pays a daily confinement benefit if an insured person is confined to an intensive care unit of a hospital as a result of an injury or sickness. No benefits are payable during the elimination period or waiting period for sickness.

Continuous Care Benefit: Pays a daily benefit if an insured person requires continuous care upon discharge from a hospital. Continuous care requires the need for a skilled nursing facility, rehabilitation facility, rehabilitation unit,
home health care, or hospice care.

Emergency Medical Services Benefit: Pays a benefit if an insured person receives emergency medical services for the treatment of a medical emergency.

3. Renewability

This is a group policy form and is renewable subject to the termination provisions specified in the policy. Specifically, the policy will terminate when Standard Life and Accident Insurance Company or the policyholder request termination of the policy, the policyholder or insured has failed to pay premiums, or the policyholder, insured or covered person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage under the terms of the policy.

4. Applicability

This filing is for new policies. There are no policies currently in force on these form numbers.

5. Morbidity

The morbidity assumptions were developed from sources that varied depending on the underlying benefit. The primary source used was Milliman's Health Cost Guidelines. This source was the basis for the development of underlying incidence and continuance factors for the majority of the benefits included in this policy.

6. Mortality

Mortality used is included in the lapse assumption. However, if the mortality rate from the 2001 VBT Ultimate ALB table exceeds the assumed lapse rate, then the mortality rate is used to model decrements at that age and duration.

7. Persistency

The assumed termination rates for this policy and riders are:

Duration	Termination
1	35%
2+	20%

8. Expenses as a percentage of premium

Expenses including profit and contingencies are are 50% of the premium.
Expenses detail (as a percentage of premium and unit cost) is as follows:

a) Commissions 20% of premium
b) Administration 19% ($50 for issue, 10% of claims paid, 10% of first year premium for marketing)
c) Premium Tax 2% of premium
d) Profit and Contingency 9% of premium

9.. Marketing Method

These products will be marketed by agents to association members.

10. Underwriting

At this time no underwriting will be used other than requiring that all applicants be members of the association to which the policy was issued.

11. Premium

The gross premium rates for this product were generated by dividing expected claim cost by .5. Because this plan is guarantee issue there is no wearing off of underwriting so I expect a flat loss ratio curve by duration. I therefore expect a 50% loss ratio across all durations, ages, genders, and benefits types and levels.

Premiums will vary by family composition. The family composition classes could be any of the following: “Insured”, “Insured + Spouse/Domestic Partner”, “Insured + Child(ren)”, and “Insured + Spouse/Domestic Partner + Children.”

The rate schedule is illustrated in attached Exhibits I. These rates vary by age band, gender, and benefit level. While the rates illustrated in Exhibit I vary by age band and gender, for some groups the rates actually billed will be on a composite basis reflecting either the age and gender distribution of the group or the default age/gender distribution shown in Exhibit II.

12. Issue Age Range

Benefits will be offered to issue ages 18 to 74.

13. Area Factors

There are no area factors for this form.

14. Average Annual Premium

The expected average annual premium for this form is $1,150.

15. Premium Modalization Rules

The modal premium factors to be applied to monthly premium rates are:

Mode	Factor
Monthly	1.0000
Quarterly	3.0000
Semi-Annual	6.0000
Annual	12.0000

16. Claim Liability and Reserves

Claim reserves will be set using appropriate actuarial methodology. There are currently no claim reserves held since these are new forms.

17. Active Life Reserves

This form has attained age rating. The slope of the premium rates by attained age is the same as the slope of the underlying morbidity curve. Thus, we do not anticipate that active life reserves will need to be held on this form.

18. Trend Assumptions

    No medical trend has been assumed in this filing.

19. Anticipated Loss Ratio

    The anticipated loss ratio is assumed to be not less than 50%.

20. Contingency and Risk Margins

    These forms are expected to produce, based upon the expected claims, an overall contingency margin that is consistent with other products written by the company.

21. Experience - Past and Future

    As these are new products, no historical experience is available.

22. Lifetime Loss Ratio

    Because these are new forms with no prior experience, the lifetime loss ratio is assumed to be not less than 50%.

23. History of Rate Adjustments

    As these are new forms, there have been no rate adjustments.

24. Number of Policyholders

    As these are new forms, there are no current policyholders.

25. Proposed Effective Date

    The rates are to become effective upon approval by your Department of Insurance. No policies will be sold until the forms and rates have been submitted and/or approved as required by your regulations.

26. Statement of Reliance

    In preparing this actuarial memorandum, I relied on morbidity assumptions and pricing information provided by Milliman, Inc. I did not audit this data but did review it for reasonableness.

27. Actuarial Certification

I, William H. Watson III, am a Member of the American Academy of Actuaries and meet its qualification standards for preparing rate filings. This actuarial memorandum has been prepared to describe the rates intended to be used for this product. This memorandum has been prepared in conformity with applicable Actuarial Standards of Practice (ASOP), including ASOP No. 8. This actuarial memorandum has been prepared for the sole purpose of demonstrating that the proposed rate schedule is reasonable and the memorandum may not be appropriate for other purposes.

In my opinion, the rates included in the actuarial memorandum are developed using reasonable assumptions and in accordance with generally accepted actuarial principles and are neither excessive nor unfair. These rates are appropriate for the class of risks for which they are intended. This filing is in compliance with state law and regulation.

Emerging experience should be carefully monitored relative to the assumptions and appropriate adjustments made to the premiums in a timely manner.

William H. Watson III, FSA, MAAA
Fellow, Society of Actuaries
Member, American Academy of Actuaries
April, 2013

Exhibit I
Standard Life and Accident Insurance Company

Monthly Attained Age Premium Rates
Base Benefits Policy Form SL-USAHC

Member Only

	Male								Female							
Benefit	Age Band 18-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60-64	Age Band 65-69	Age Band 70-74	Age Band 18-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60-64	Age Band 65-69	Age Band 70-74
Hospital Confinement																
$50/Day, 0 Day EP, 10 Day Max	0.701	1.350	1.837	2.523	3.409	4.948	8.033	10.683	0.890	1.639	1.935	2.497	2.914	3.996	7.173	9.754
$50/Day, 0 Day EP, 30 Day Max	0.773	1.518	2.067	2.838	3.835	5.738	9.527	12.945	0.956	1.761	2.078	2.808	3.278	4.634	8.623	12.016
$50/Day, 0 Day EP, 60 Day Max	0.777	1.529	2.082	2.859	3.863	5.795	9.642	13.126	0.959	1.768	2.086	2.828	3.303	4.680	8.728	12.183
$50/Day, 0 Day EP, 90 Day Max	0.778	1.533	2.086	2.866	3.872	5.813	9.679	13.186	0.960	1.770	2.089	2.835	3.310	4.695	8.765	12.243
$50/Day, 0 Day EP, 365 Day Max	0.778	1.534	2.088	2.868	3.874	5.819	9.693	13.210	0.961	1.771	2.090	2.837	3.312	4.700	8.779	12.268
$50/Day, 3 Day EP, 10 Day Max	0.568	0.815	0.999	1.263	1.607	2.429	4.043	5.646	0.534	0.770	0.863	1.233	1.397	2.001	3.812	5.479
$50/Day, 3 Day EP, 30 Day Max	0.630	0.941	1.160	1.475	1.886	2.949	5.010	7.114	0.583	0.850	0.956	1.441	1.637	2.425	4.764	6.966
$50/Day, 3 Day EP, 60 Day Max	0.633	0.951	1.173	1.494	1.911	2.999	5.112	7.273	0.587	0.856	0.963	1.459	1.658	2.466	4.857	7.113
$50/Day, 3 Day EP, 90 Day Max	0.635	0.954	1.178	1.500	1.918	3.016	5.146	7.328	0.588	0.858	0.965	1.465	1.665	2.480	4.890	7.168
$50/Day, 3 Day EP, 365 Day Max	0.635	0.955	1.179	1.501	1.921	3.021	5.158	7.348	0.588	0.859	0.966	1.467	1.667	2.483	4.903	7.189
$50/Day, 7 Day EP, 10 Day Max	0.519	0.613	0.680	0.783	0.922	1.366	2.248	3.202	0.423	0.498	0.527	0.752	0.819	1.159	2.189	3.196
$50/Day, 7 Day EP, 30 Day Max	0.575	0.700	0.783	0.908	1.075	1.643	2.743	3.947	0.459	0.546	0.580	0.873	0.954	1.391	2.680	3.951
$50/Day, 7 Day EP, 60 Day Max	0.578	0.709	0.795	0.924	1.097	1.686	2.831	4.083	0.462	0.551	0.586	0.888	0.973	1.426	2.761	4.078
$50/Day, 7 Day EP, 90 Day Max	0.580	0.712	0.799	0.929	1.103	1.701	2.861	4.132	0.463	0.553	0.588	0.893	0.978	1.438	2.791	4.128
$50/Day, 7 Day EP, 365 Day Max	0.580	0.713	0.800	0.931	1.105	1.705	2.871	4.148	0.463	0.553	0.589	0.894	0.980	1.442	2.801	4.146
Hospital Admission																
$50 Benefit	0.208	0.382	0.519	0.713	0.963	1.307	2.027	2.559	0.287	0.528	0.624	0.705	0.823	1.055	1.697	2.133
Hospital ICU																
$50/Day, 10 Day Max	0.073	0.133	0.181	0.249	0.337	0.456	0.708	0.893	0.100	0.185	0.218	0.247	0.288	0.368	0.593	0.745
$50/Day, 15 Day Max	0.073	0.133	0.182	0.250	0.338	0.458	0.710	0.897	0.101	0.185	0.218	0.247	0.288	0.370	0.594	0.748
$50/Day, 20 Day Max	0.073	0.133	0.182	0.250	0.338	0.458	0.710	0.897	0.101	0.185	0.218	0.248	0.288	0.370	0.594	0.748
$50/Day, 30 Day Max	0.073	0.133	0.182	0.250	0.338	0.458	0.710	0.897	0.101	0.185	0.218	0.248	0.288	0.370	0.594	0.748
Emergency Medical Services																
$25/Day, 1 Day/Year	0.248	0.223	0.225	0.234	0.261	0.293	0.354	0.354	0.402	0.278	0.271	0.290	0.307	0.320	0.333	0.333
$25/Day, 2 Days/Year	0.383	0.343	0.346	0.361	0.401	0.452	0.545	0.545	0.618	0.427	0.416	0.447	0.472	0.492	0.513	0.513
Continuous Care																
$25/Day, 10 Day Max	0.012	0.027	0.033	0.040	0.058	0.090	0.123	0.130	0.016	0.028	0.033	0.039	0.058	0.096	0.134	0.255
$25/Day, 30 Day Max	0.018	0.041	0.051	0.062	0.088	0.137	0.186	0.198	0.023	0.043	0.052	0.059	0.088	0.146	0.204	0.387

Exhibit I
Standard Life and Accident Insurance Company

Monthly Attained Age Premium Rates
Base Benefits Policy Form SL-USAHC

Member and Spouse

	Male								Female							
	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band
Benefit	18-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	18-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
Hospital Confinement																
$50/Day, 0 Day EP, 10 Day Max	1.591	2.989	3.772	5.020	6.323	8.944	15.207	20.438	1.591	2.989	3.772	5.020	6.323	8.944	15.207	20.438
$50/Day, 0 Day EP, 30 Day Max	1.728	3.279	4.145	5.647	7.113	10.372	18.149	24.961	1.728	3.279	4.145	5.647	7.113	10.372	18.149	24.961
$50/Day, 0 Day EP, 60 Day Max	1.736	3.297	4.168	5.688	7.165	10.475	18.369	25.309	1.736	3.297	4.168	5.688	7.165	10.475	18.369	25.309
$50/Day, 0 Day EP, 90 Day Max	1.738	3.303	4.175	5.701	7.182	10.508	18.444	25.429	1.738	3.303	4.175	5.701	7.182	10.508	18.444	25.429
$50/Day, 0 Day EP, 365 Day Max	1.739	3.305	4.178	5.704	7.186	10.519	18.473	25.478	1.739	3.305	4.178	5.704	7.186	10.519	18.473	25.478
$50/Day, 3 Day EP, 10 Day Max	1.102	1.585	1.863	2.495	3.003	4.430	7.854	11.125	1.102	1.585	1.863	2.495	3.003	4.430	7.854	11.125
$50/Day, 3 Day EP, 30 Day Max	1.213	1.791	2.116	2.916	3.523	5.374	9.774	14.080	1.213	1.791	2.116	2.916	3.523	5.374	9.774	14.080
$50/Day, 3 Day EP, 60 Day Max	1.220	1.807	2.136	2.953	3.569	5.465	9.968	14.386	1.220	1.807	2.136	2.953	3.569	5.465	9.968	14.386
$50/Day, 3 Day EP, 90 Day Max	1.223	1.813	2.143	2.965	3.583	5.496	10.036	14.495	1.223	1.813	2.143	2.965	3.583	5.496	10.036	14.495
$50/Day, 3 Day EP, 365 Day Max	1.223	1.814	2.145	2.968	3.588	5.504	10.061	14.537	1.223	1.814	2.145	2.968	3.588	5.504	10.061	14.537
$50/Day, 7 Day EP, 10 Day Max	0.942	1.110	1.207	1.535	1.741	2.525	4.438	6.398	0.942	1.110	1.207	1.535	1.741	2.525	4.438	6.398
$50/Day, 7 Day EP, 30 Day Max	1.034	1.246	1.363	1.781	2.029	3.033	5.423	7.898	1.034	1.246	1.363	1.781	2.029	3.033	5.423	7.898
$50/Day, 7 Day EP, 60 Day Max	1.040	1.260	1.381	1.813	2.069	3.112	5.592	8.161	1.040	1.260	1.381	1.813	2.069	3.112	5.592	8.161
$50/Day, 7 Day EP, 90 Day Max	1.043	1.265	1.388	1.823	2.082	3.139	5.652	8.260	1.043	1.265	1.388	1.823	2.082	3.139	5.652	8.260
$50/Day, 7 Day EP, 365 Day Max	1.043	1.266	1.389	1.825	2.085	3.147	5.672	8.293	1.043	1.266	1.389	1.825	2.085	3.147	5.672	8.293
Hospital Admission																
$50 Benefit	0.494	0.910	1.143	1.418	1.787	2.362	3.723	4.693	0.494	0.910	1.143	1.418	1.787	2.362	3.723	4.693
Hospital ICU																
$50/Day, 10 Day Max	0.173	0.318	0.398	0.496	0.624	0.824	1.300	1.638	0.173	0.318	0.398	0.496	0.624	0.824	1.300	1.638
$50/Day, 15 Day Max	0.173	0.318	0.400	0.497	0.626	0.828	1.304	1.644	0.173	0.318	0.400	0.497	0.626	0.828	1.304	1.644
$50/Day, 20 Day Max	0.173	0.318	0.400	0.498	0.626	0.828	1.304	1.644	0.173	0.318	0.400	0.498	0.626	0.828	1.304	1.644
$50/Day, 30 Day Max	0.173	0.318	0.400	0.498	0.626	0.828	1.304	1.644	0.173	0.318	0.400	0.498	0.626	0.828	1.304	1.644
Emergency Medical Services																
$25/Day, 1 Day/Year	0.650	0.501	0.496	0.524	0.568	0.613	0.687	0.687	0.650	0.501	0.496	0.524	0.568	0.613	0.687	0.687
$25/Day, 2 Days/Year	1.001	0.770	0.762	0.808	0.873	0.943	1.058	1.058	1.001	0.770	0.762	0.808	0.873	0.943	1.058	1.058
Continuous Care																
$25/Day, 10 Day Max	0.028	0.055	0.067	0.079	0.115	0.186	0.257	0.385	0.028	0.055	0.067	0.079	0.115	0.186	0.257	0.385
$25/Day, 30 Day Max	0.041	0.084	0.103	0.121	0.175	0.283	0.390	0.584	0.041	0.084	0.103	0.121	0.175	0.283	0.390	0.584

Exhibit I
Standard Life and Accident Insurance Company

Monthly Attained Age Premium Rates
Base Benefits Policy Form SL-USAHC

Member and Child(ren)

	Male								Female							
	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band
Benefit	18-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	18-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
Hospital Confinement																
$50/Day, 0 Day EP, 10 Day Max	1.842	2.644	3.056	3.651	4.425	5.849	9.084	11.734	2.033	2.853	3.047	3.499	3.781	4.836	8.224	10.805
$50/Day, 0 Day EP, 30 Day Max	2.027	2.942	3.408	4.078	4.952	6.728	10.682	14.100	2.213	3.096	3.301	3.911	4.232	5.558	9.778	13.171
$50/Day, 0 Day EP, 60 Day Max	2.038	2.961	3.431	4.106	4.985	6.791	10.803	14.287	2.223	3.110	3.315	3.937	4.261	5.609	9.889	13.345
$50/Day, 0 Day EP, 90 Day Max	2.042	2.968	3.438	4.115	4.997	6.811	10.843	14.350	2.226	3.115	3.321	3.946	4.271	5.626	9.929	13.407
$50/Day, 0 Day EP, 365 Day Max	2.042	2.969	3.439	4.117	4.999	6.817	10.857	14.374	2.227	3.116	3.322	3.947	4.272	5.631	9.943	13.432
$50/Day, 3 Day EP, 10 Day Max	1.204	1.537	1.679	1.891	2.173	2.931	4.628	6.232	1.172	1.447	1.483	1.791	1.880	2.469	4.397	6.065
$50/Day, 3 Day EP, 30 Day Max	1.347	1.755	1.927	2.184	2.524	3.515	5.670	7.774	1.302	1.613	1.655	2.071	2.182	2.953	5.424	7.626
$50/Day, 3 Day EP, 60 Day Max	1.357	1.772	1.947	2.210	2.555	3.571	5.778	7.940	1.312	1.626	1.668	2.095	2.209	2.999	5.523	7.779
$50/Day, 3 Day EP, 90 Day Max	1.360	1.777	1.954	2.217	2.564	3.588	5.814	7.995	1.314	1.630	1.672	2.102	2.216	3.014	5.558	7.835
$50/Day, 3 Day EP, 365 Day Max	1.362	1.780	1.956	2.219	2.568	3.594	5.827	8.017	1.316	1.632	1.674	2.105	2.219	3.019	5.572	7.858
$50/Day, 7 Day EP, 10 Day Max	0.980	1.135	1.173	1.239	1.332	1.729	2.673	3.626	0.884	0.988	0.976	1.156	1.169	1.499	2.613	3.620
$50/Day, 7 Day EP, 30 Day Max	1.091	1.285	1.335	1.418	1.534	2.049	3.218	4.421	0.976	1.094	1.082	1.325	1.346	1.771	3.155	4.426
$50/Day, 7 Day EP, 60 Day Max	1.099	1.300	1.352	1.439	1.560	2.097	3.311	4.562	0.984	1.105	1.094	1.346	1.368	1.810	3.241	4.558
$50/Day, 7 Day EP, 90 Day Max	1.104	1.306	1.359	1.447	1.570	2.114	3.343	4.614	0.988	1.111	1.099	1.354	1.376	1.824	3.273	4.611
$50/Day, 7 Day EP, 365 Day Max	1.104	1.307	1.360	1.448	1.571	2.118	3.353	4.630	0.988	1.111	1.100	1.354	1.378	1.827	3.283	4.628
Hospital Admission																
$50 Benefit	0.552	0.772	0.887	1.053	1.270	1.578	2.344	2.876	0.631	0.895	0.960	1.007	1.085	1.309	2.014	2.450
Hospital ICU																
$50/Day, 10 Day Max	0.192	0.269	0.308	0.367	0.443	0.550	0.817	1.003	0.220	0.312	0.334	0.351	0.378	0.456	0.702	0.855
$50/Day, 15 Day Max	0.193	0.270	0.311	0.369	0.445	0.553	0.821	1.008	0.222	0.313	0.336	0.353	0.380	0.459	0.705	0.859
$50/Day, 20 Day Max	0.193	0.270	0.311	0.369	0.445	0.553	0.821	1.008	0.222	0.313	0.336	0.354	0.380	0.459	0.705	0.859
$50/Day, 30 Day Max	0.193	0.270	0.311	0.369	0.445	0.553	0.821	1.008	0.222	0.313	0.336	0.354	0.380	0.459	0.705	0.859
Emergency Medical Services																
$25/Day, 1 Day/Year	0.731	0.771	0.741	0.711	0.690	0.674	0.799	0.799	0.885	0.791	0.741	0.714	0.673	0.676	0.777	0.777
$25/Day, 2 Days/Year	1.124	1.185	1.139	1.094	1.061	1.037	1.228	1.228	1.361	1.216	1.139	1.098	1.035	1.038	1.196	1.196
Continuous Care																
$25/Day, 10 Day Max	0.029	0.047	0.052	0.058	0.073	0.104	0.139	0.146	0.034	0.047	0.051	0.055	0.071	0.109	0.151	0.271
$25/Day, 30 Day Max	0.045	0.072	0.080	0.089	0.112	0.158	0.211	0.223	0.051	0.073	0.078	0.083	0.108	0.166	0.229	0.412

Exhibit I
Standard Life and Accident Insurance Company

Monthly Attained Age Premium Rates
Base Benefits Policy Form SL-USAHC

Member and Family

	Male								Female							
	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band	Age Band
Benefit	18-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	18-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
Hospital Confinement																
$50/Day, 0 Day EP, 10 Day Max	3.041	4.584	5.272	6.335	7.452	9.963	16.140	21.371	2.976	4.448	5.096	6.152	7.312	9.845	16.257	21.488
$50/Day, 0 Day EP, 30 Day Max	3.323	5.034	5.795	7.092	8.355	11.492	19.176	25.988	3.252	4.884	5.601	6.892	8.201	11.362	19.304	26.116
$50/Day, 0 Day EP, 60 Day Max	3.340	5.061	5.826	7.141	8.413	11.601	19.402	26.342	3.268	4.910	5.631	6.940	8.258	11.471	19.531	26.471
$50/Day, 0 Day EP, 90 Day Max	3.345	5.071	5.837	7.158	8.432	11.637	19.479	26.464	3.273	4.920	5.642	6.956	8.277	11.506	19.608	26.593
$50/Day, 0 Day EP, 365 Day Max	3.346	5.073	5.840	7.161	8.437	11.648	19.507	26.513	3.274	4.922	5.645	6.959	8.281	11.517	19.637	26.642
$50/Day, 3 Day EP, 10 Day Max	1.910	2.475	2.699	3.228	3.633	4.998	8.375	11.646	1.874	2.399	2.601	3.127	3.555	4.932	8.440	11.711
$50/Day, 3 Day EP, 30 Day Max	2.125	2.794	3.059	3.742	4.232	6.014	10.361	14.667	2.084	2.708	2.948	3.628	4.144	5.940	10.434	14.740
$50/Day, 3 Day EP, 60 Day Max	2.140	2.819	3.088	3.788	4.285	6.111	10.561	14.978	2.099	2.733	2.976	3.672	4.197	6.036	10.635	15.052
$50/Day, 3 Day EP, 90 Day Max	2.145	2.827	3.097	3.801	4.301	6.143	10.629	15.089	2.103	2.740	2.985	3.685	4.212	6.068	10.704	15.163
$50/Day, 3 Day EP, 365 Day Max	2.147	2.830	3.100	3.805	4.306	6.153	10.656	15.131	2.106	2.744	2.988	3.689	4.217	6.078	10.730	15.206
$50/Day, 7 Day EP, 10 Day Max	1.527	1.754	1.812	2.066	2.197	2.936	4.815	6.775	1.501	1.699	1.741	1.992	2.140	2.889	4.862	6.822
$50/Day, 7 Day EP, 30 Day Max	1.690	1.967	2.041	2.375	2.539	3.494	5.845	8.319	1.660	1.905	1.962	2.293	2.476	3.440	5.898	8.372
$50/Day, 7 Day EP, 60 Day Max	1.702	1.989	2.066	2.413	2.585	3.577	6.018	8.587	1.673	1.927	1.985	2.330	2.521	3.523	6.071	8.641
$50/Day, 7 Day EP, 90 Day Max	1.709	1.997	2.076	2.426	2.600	3.607	6.080	8.689	1.679	1.935	1.995	2.342	2.536	3.553	6.134	8.742
$50/Day, 7 Day EP, 365 Day Max	1.709	1.998	2.078	2.429	2.603	3.614	6.100	8.722	1.679	1.936	1.997	2.345	2.539	3.560	6.154	8.776
Hospital Admission																
$50 Benefit	0.932	1.391	1.596	1.814	2.127	2.669	4.005	4.974	0.912	1.350	1.543	1.759	2.085	2.633	4.040	5.009
Hospital ICU																
$50/Day, 10 Day Max	0.324	0.485	0.555	0.633	0.742	0.931	1.398	1.736	0.317	0.471	0.537	0.614	0.728	0.918	1.410	1.748
$50/Day, 15 Day Max	0.327	0.487	0.559	0.636	0.745	0.935	1.403	1.743	0.320	0.473	0.540	0.616	0.730	0.923	1.415	1.755
$50/Day, 20 Day Max	0.327	0.487	0.559	0.637	0.745	0.935	1.403	1.743	0.320	0.473	0.540	0.617	0.730	0.923	1.415	1.755
$50/Day, 30 Day Max	0.327	0.487	0.559	0.637	0.745	0.935	1.403	1.743	0.320	0.473	0.540	0.617	0.730	0.923	1.415	1.755
Emergency Medical Services																
$25/Day, 1 Day/Year	1.264	1.176	1.130	1.080	1.045	1.044	1.082	1.082	1.236	1.118	1.056	1.003	0.986	0.994	1.131	1.131
$25/Day, 2 Days/Year	1.944	1.807	1.737	1.662	1.606	1.606	1.665	1.665	1.902	1.719	1.622	1.544	1.515	1.529	1.741	1.741
Continuous Care																
$25/Day, 10 Day Max	0.050	0.080	0.090	0.100	0.133	0.202	0.271	0.400	0.049	0.078	0.087	0.097	0.130	0.200	0.273	0.401
$25/Day, 30 Day Max	0.076	0.123	0.139	0.152	0.202	0.307	0.412	0.607	0.074	0.119	0.134	0.148	0.199	0.304	0.415	0.609

Exhibit II
Standard Life and Accident Insurance Company

Default Age/Gender Distributions For Composite Rates

Member Only

Age	Male	Female
18-39	24.2%	22.0%
40-44	4.8%	4.8%
45-49	4.9%	5.7%
50-54	4.7%	6.2%
55-59	4.2%	6.1%
60-64	3.1%	5.3%
65-69	0.8%	1.3%
70-74	0.8%	1.3%

Member and Spouse

Age	Male	Female
18-39	20.5%	10.5%
40-44	10.0%	4.9%
45-49	10.4%	5.5%
50-54	9.4%	5.5%
55-59	7.9%	4.2%
60-64	5.6%	2.3%
65-69	1.4%	0.4%
70-74	1.4%	0.4%

Member and Child(ren)

Age	Male	Female
18-39	19.0%	27.6%
40-44	7.9%	10.8%
45-49	7.4%	9.6%
50-54	4.9%	6.1%
55-59	2.4%	2.5%
60-64	0.8%	0.6%
65-69	0.1%	0.1%
70-74	0.1%	0.1%

Member and Family

Age	Male	Female
18-39	20.5%	10.5%
40-44	10.0%	4.9%
45-49	10.4%	5.5%
50-54	9.4%	5.5%
55-59	7.9%	4.2%
60-64	5.6%	2.3%
65-69	1.4%	0.4%
70-74	1.4%	0.4%