PACIFIC LIFE

Pacific Life & Annuity Company

Pacific Life & Annuity Company Workforce Benefits Division Claims/
P.O. Box 2387, Omaha, NE 68103
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GROUP HOSPITAL INDEMNITY CERTIFICATE OF INSURANCE

CERTIFICATE OF INSURANCE: This Certificate, which is part of the Policy, is issued to You under the Policy. The Policy is a contract between Us and the Policyholder. The Policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms and provisions of this Certificate are different from the Policy, the Policy will govern. The Policy may be inspected at the office of the Policyholder during normal business hours.

CONSIDERATION: Coverage under the Policy is issued in consideration of Your enrollment form or other form of application, the payment of the first premium, and other eligibility requirements as defined by this Certificate. This Certificate replaces all certificates and certificate riders, if any, previously issued to You under the Policy.

RIGHT TO EXAMINE: If You do not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

RENEWABILITY – OPTIONALLY RENEWABLE: The Policy and this Certificate may be changed in whole or in part or cancelled by agreement between Us and the Policyholder. Such an action may be taken without the consent or notice to You or anyone covered under the Policy. Only an authorized officer at Our Home Office can approve a change. The approval must be in writing and endorsed on or attached to the Policy. No other person, including an agent, may change the Policy or Certificate or waive any of its provisions. Premiums are subject to change.

Signed for Pacific Life & Annuity Company by:

President

Secretary

THIS CERTIFICATE PROVIDES LIMITED BENEFITS UNDER A NON-PARTICIPATING POLICY. PLEASE READ THIS CERTIFICATE CAREFULLY. Benefits provided are supplemental and are not intended to cover all medical expenses.

THIS CERTIFICATE MAY BE SUBJECT TO A PREMIUM INCREASE OR NONRENEWAL ON ANY POLICY ANNIVERSARY, AND INSURED COVERAGE MAY END DUE TO ATTAINMENT OF A SPECIFIED AGE.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us at www.medicare.gov/publications.

SECTION 1 - TABLE OF CONTENTS

SECTION 2 – CERTIFICATE SCHEDULE

Policyholder:	Coppell Independent School District
Policy Number:	HIMP1716273625
Policy Effective Date:	September 1, 2025
Policy Anniversary:	September 1
Situs State:	Texas

SCHEDULE OF BENEFITS

	Benefit Amount		
Confinement	**Primary Insured**	**Spouse**	**Dependent Child(ren)**
Hospital Admission	$1,500	$1,500	$1,500
Daily Hospital Confinement	$150	$150	$150
Daily ICU Confinement	$300	$300	$300
Inpatient Rehabilitation Unit Confinement	$75	$75	$75
Substance Abuse Facility Confinement	$150	$150	$150
Mental & Nervous Facility Confinement	$150	$150	$150
Newborn Nursery Confinement	$200	$200	$200
	Benefit Amount		
Outpatient Treatment	**Primary Insured**	**Spouse**	**Dependent Child(ren)**
Observation Room Treatment	$200	$200	$200

CONTINUATION OF COVERAGE DURING A STRIKE: 6 Months

CONTINUATION OF COVERAGE DURING A LAYOFF: 3 Months

SECTION 3 – ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY: You and Your Dependent(s), if applicable, are eligible for coverage on the later of the Policy Effective Date or date You enter an Eligible Class, as defined by the Policyholder's Application. Your eligibility may also be subject to eligibility waiting periods from the date You enter an Eligible Class, as determined by the Policyholder for Your Eligible Class.

If We require Evidence of Insurability at the point of sale, then Evidence of Insurability will always be required for any changes to the coverage.

If We do not require Evidence of Insurability at the point of sale, Evidence of Insurability will only be required if:

1. You voluntarily canceled coverage and are reapplying;
2. You are applying for an amount of coverage over the guaranteed issue limit;
3. You are applying for an increase in or addition to coverage any time after Your Initial Enrollment period;
4. You or a Dependent did not enroll within 31 days of eligibility; or
5. Our minimum participation requirements were not met.

DEFERRED DEPENDENT ELIGIBILITY: We will defer a Dependent's effective date of coverage if the Dependent is Confined to a Hospital or other health care facility. In that case, We will defer the Dependent's effective date of coverage until the day after the date they are discharged from such facility.

If a Dependent was covered under a prior plan at replacement, this language will not apply to the amount of coverage that was in force with the prior plan.

This provision does not apply to newborn children.

EFFECTIVE DATE: If You are eligible for coverage and have done what is required to obtain coverage, as explained in the Eligibility provision, your coverage begins at 12:01 AM PST on the first day You became eligible for coverage.

You must be in Active Employment, performing the major duties of your regular job and working the required number of hours at the location required by your Policyholder on the date your coverage is scheduled to begin. If you do not meet this requirement for any reason other than sickness or Injury, your coverage will not begin until you return to being in Active Employment, performing the major duties of your regular job and working the required number of hours at the location required by Your Policyholder.

Your coverage may be scheduled to begin on or during one of the following:
1. A holiday;
2. A vacation day;
3. A day You are not scheduled to work;
4. A temporary Layoff of less than 60 days;
5. An approved Leave of Absence of 60 days or less that is not due to a sickness or Injury;
6. A period of absence that is less than 60 days.

If this happens, coverage will still begin on that same day if You were in Active Employment, performing the major duties of your regular job and working the required number of hours at the location required by Your Policyholder on your last regularly scheduled workday.

If You are not in Active Employment because of a sickness or Injury, coverage will still begin on the date it was scheduled to start if all the following are true:
1. The Policy replaced a prior policy and there was no interruption in coverage.
2. You were covered by the prior policy at the time it ended.
3. You are no longer eligible for coverage under the prior policy.
4. You are not receiving and are not eligible to receive benefits under the prior policy.

A prior policy is the policy that Your Policyholder had immediately before this Policy. For it to be considered a prior policy, it must have ended the day before this policy began.

NEWBORN/ADOPTED/FOSTERED CHILDREN: A newborn child that is a Dependent, if born while You are covered under the Policy, will automatically be covered from the moment of birth until the 60th day of age. If You wish to continue coverage for the Dependent child beyond the initial 60-day period, enrollment for such child, a notice of birth, and additional premium, if any, must be submitted to Us or the Policy Administrator within 60 days of birth.

Coverage for newborn children will also include coverage for:

1. any newborn child adopted by You, or Your Spouse from the moment of birth, if a petition for adoption was filed within 31 days of the birth of the child; and
2. a child adopted by You or Your Spouse from the date of the filing of the petition for adoption, including when You or Your Spouse are a party to a suit in which You or Your Spouse seek to adopt the child; and
3. a child fostered by You from the date of placement for fostering.

Coverage shall terminate upon the dismissal or denial of a petition for adoption in cases of adopted children, or upon the termination of Your foster obligations, in cases of fostered children. Coverage for the adopted or fostered child will not continue past 60 days after the date coverage becomes effective, as stated above, unless We are notified by the end of such 60-day period of the addition of

such adopted or fostered child, and any applicable additional premium is paid.

CHANGES IN COVERAGE: You may change or cancel Your or Your Dependent's coverage at any time during an Enrollment Period or within 60 days of a Qualifying Life Event. A requested change or cancellation of Your or Your Dependent's coverage will become effective on:

1. the first day of the month following the date You submit a request for the change or cancellation;
2. the first day of the month following the date of the Qualifying Life Event if the change is requested within 60 days of a Qualifying Life Event; or
3. the Enrollment Period Effective Date, if the change is made during an Enrollment Period.

Any unearned premium created by a cancellation will be promptly returned.

Coverage will end for each Dependent as of the date they no longer qualify as a Dependent as defined in this Certificate. You are responsible for notifying Us of any change in Dependent status. Our sole liability once notified is the refund of any unearned premium for the time period for which they no longer qualified as a Dependent.

SECTION 4 – BENEFITS

CONFINEMENT

Except as described in the ICU Benefits If more than one Confinement occurs on the same day, only the highest applicable benefit is payable.

Hospital Admission
We will pay the Hospital Admission Benefit Amount shown in the Schedule of Benefits for the first day an Insured is Confined to a Hospital as an Inpatient or has an Observation Unit Long Stay as the result of a Covered Accident or Covered Sickness.

The Confinement or Observation Unit Long Stay must begin within 180 days after a Covered Accident occurs. This benefit is payable once per Covered Accident or Covered Sickness and is payable up to 10 days per Plan Year for each Insured. This benefit is only payable once per day, even if the Confinement or Observation Unit Long Stay is the result of more than one Covered Accident or Covered Sickness.

Daily Hospital Confinement
We will pay the Daily Hospital Confinement Benefit Amount shown in the Schedule of Benefits for each day an Insured is Confined to a Hospital as an Inpatient or each day of an Observation Unit Long Stay as the result of a Covered Accident or Covered Sickness. The Daily Hospital Confinement Benefit Amount per day is based upon the total days of the Confinement, as shown in the Schedule of Benefits.

The Confinement or Observation Unit Long Stay must begin within 180 days after a Covered Accident occurs. This benefit is payable for up to 10 days per Plan Year for each Insured.

This benefit is not payable on the same day as the Hospital Admission benefit.

Daily ICU Confinement
We will pay the Daily ICU Confinement Benefit Amount shown in the Schedule of Benefits for each day an Insured is Confined to an Intensive Care Unit (ICU) as an Inpatient as the result of a Covered Accident or Covered Sickness. The Daily ICU Confinement Benefit Amount per day is based upon the total days of the ICU Confinement, as shown in the Schedule of Benefits. The Daily ICU Confinement Benefit is payable on the same day as a Hospital Confinement benefit.

The Confinement must begin within 180 days after a Covered Accident occurs. This benefit is payable for up to 10 days per Plan Year for each Insured.

This benefit is not payable on the same day as the ICU Admission benefit.

Inpatient Rehabilitation Unit Confinement
We will pay the Inpatient Rehabilitation Unit Confinement Benefit Amount shown in the Schedule of Benefits for each day an Insured is Confined to a Rehabilitation Unit as an Inpatient following a Confinement in a Hospital as the result of a Covered Accident or Covered Sickness.

The Treatment must begin within 60 days after the date of discharge from the Hospital. This benefit is payable for up to 30 days per Plan Year for each Insured.

Substance Abuse Facility Confinement
We will pay the Substance Abuse Facility Confinement Benefit Amount shown in the Schedule of Benefits for each day an Insured is Confined to a Substance Abuse Facility as an Inpatient for Treatment of Substance Abuse.

This benefit is payable for up to 30 days per Plan Year for each Insured.

Mental & Nervous Disorder Facility Confinement
We will pay the Mental & Nervous Disorder Facility Confinement Benefit Amount shown in the Schedule of Benefits for each day an Insured is Confined to a Mental & Nervous Disorders Facility as an Inpatient for Treatment of a Mental or Nervous Disorder.

This benefit is payable for up to 30 days per Plan Year for each Insured.

Newborn Nursery Confinement
We will pay the Newborn Nursery Confinement Benefit Amount shown in the Schedule of Benefits for the first day an Insured's newborn Dependent Child is Confined to a Hospital as an Inpatient for routine care following birth.

OUTPATIENT TREATMENT

No more than one Outpatient Treatment benefit is payable per day. If an Insured meets the conditions for more than one Outpatient Treatment benefit on the same day, only the highest applicable benefit is payable. Outpatient Treatment benefits are not payable for routine health examinations, immunizations, Physical Therapy, or other therapy services.

Observation Room Treatment
We will pay the Observation Room Treatment Benefit Amount shown in the Schedule of Benefits for each day an Insured has an Observation Room Short Stay as the result of a Covered Accident or Covered Sickness. The Treatment must occur within 180 of a Hospital Confinement.

The Treatment must begin within 180 days after a Covered Accident occurs. This benefit is payable once per Covered Accident or Covered Sickness and is payable up to 2 days per Plan Year for each

Insured.

Continuation of Coverage During a Strike or Layoff

We will waive the current month's premium and continue coverage for this Certificate if You have not worked due to a Strike or Layoff for at least 14 of the 30 days prior to Your premium due date while covered under this Certificate. If You are disabled and premiums are already being waived under a waiver of premium benefit, if applicable, you are not eligible for continuation of coverage under this rider. Premiums will not be waived if Your coverage under this Certificate terminated due to failure to make required premium payments.

Strike

Premiums will be waived and coverage will continue for up to six (6) months during a Strike. Coverage under this benefit will cease automatically at the end of the six (6) month period if the Strike is still in effect on such date. If the Strike ends before the end of the six (6) month period, premium payments are to be resumed on the day after the Strike ends.

If You return to work after a Strike and then stop working again due to a Strike in less than 30 days, this will be considered the same Strike for purposes of calculating the six (6) month benefit. The Strike must be confirmed by Your union or employer on a monthly basis. You are responsible for providing Us with the appropriate contact information for Your union.

Layoff

Premiums will be waived and coverage will continue if You are Laid Off from Your full-time job while covered under this Certificate. Premiums will be waived for up to six (6) months. Premiums will no longer be waived if any of the following occur:

1. You are re-employed by the employer;
2. You are employed by a new employer; and
3. You refuse to provide written proof of Your continuing Layoff upon Our request.

We will not waive the premiums if the Layoff is a result of:

1. voluntary termination of Your job;
2. termination of a part-time, secondary, or temporary job;
3. retirement;
4. termination of Your job because of performance reasons such as performance deficiencies, attendance problems, or unacceptable behavior; or
5. routine, regularly-scheduled, or seasonal shutdowns.

If You return to work after a Layoff and then stop working again due to a Layoff in less than 30 days, this will be considered the same Layoff for purposes of calculating the six month benefit. You must obtain written confirmation from Your employer that you were subject to a Layoff.

SECTION 5 – LIMITATIONS AND EXCLUSIONS

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

1. voluntary intoxication (as defined by the law of the jurisdiction in which such intoxication occurred) or while under the influence of any narcotic, drug, or controlled substance, unless administered by or taken according to the instructions of a Physician or Medical Professional;
2. an Insured's voluntary intoxication through the use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;
3. participation in any felonious activity, as defined and determined by the law of the jurisdiction where the cause of loss occurs;
4. intentional self-harm or attempting or committing suicide, whether sane or not;
5. war or any act of war, whether declared or undeclared, or any act related to war while serving in the military forces or any auxiliary unit thereto (the pro-rata portion of any premium paid for any such Insured will be refunded upon receipt of Your written request);
6. Treatment for termination of pregnancy, except for Medically Necessary procedures as determined by a Physician;
7. Treatment for contraception, sterilization, tubal ligation, vasectomy, reversal of vasectomy, reversal of tubal ligation, and any incidental Treatment, including follow up care and Treatment due to complications;
8. Treatment for infertility such as artificial insemination, in vitro fertilization, zygote or gamete intrafallopian transfer, cryopreserved embryo transfers, test tube fertilization, and any incidental Treatment, including follow up care and Treatment due to complications;
9. Treatment for sex reassignment therapy, including hormone therapy to modify secondary sex characteristics, sex reassignment surgery to alter primary sex characteristics, and other procedures altering appearance, including permanent hair removal;
10. the initial Confinement of a newborn following Childbirth for routine post-natal care, including any Confinement at a different Hospital or facility to which a newborn was transferred, except as provided for in the Newborn Nursery Confinement benefit;
11. Treatment for Substance Abuse;
12. Treatment for Mental or Nervous Disorders, except for the following disorders which meet the definition and criteria set forth in the current Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association (APA):
    a. Mental Retardation;
    b. Pervasive Developmental Disorders;
    c. Motor Skills Disorder;
    d. Delirium, Dementia, and Amnesic and Other Cognitive Disorders; and
    e. Narcolepsy and Sleep Disorders related to a General Medical Condition.
13. an Injury or Sickness incurred while an Insured is an active member of the armed forces of any nation or authority;

14. an Injury that occurs while an Insured is engaged in an illegal occupation or activity, or legally incarcerated in a penal or correctional institution (illegality is determined by the law of the governing jurisdiction);
15. cosmetic Surgery or other elective procedure that is not Medically Necessary, except for reconstructive surgery incidental to or following surgery for trauma to the affected body part;
16. Treatment received outside the United States, its territories, or Canada, except for Emergency Care received within the first 30 days of an Injury or Sickness;
17. Treatment provided by an Insured or a Family Member, or at a facility, office, or other location owned or operated by an Insured or a Family Member. The Family Caregiver Benefit is not subject to this exclusion;
18. Treatment for dental care or dental care procedures;
19. operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
20. travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
21. participation in any Organized Sport in a professional or semi-professional capacity;
22. riding or driving an air, land, or water vehicle in any organized and scheduled race, speed, or endurance contest;
23. participation in base jumping, bungee jumping, cliff jumping, kite surfing, kiteboarding, luging, parachuting, paragliding, parakiting, parasailing, ski jumping, skydiving, spelunking, tricking, or wingsuit flying; or
24. an On the Job Injury.

Additionally, no benefits will be paid for any Treatment or Confinement that occurs prior to an Insured being covered under the Certificate, subject to the Pre-Existing Condition Limitation.

SECTION 6 – CONTINUATION PORTABILITY

CONTINUATION COVERAGE: If You temporarily stop working, there may be a limited period of time during which You can keep Your coverage.

Premiums must continue to be paid during this time. Please contact Your Policyholder if You have any questions. Details on when You can keep this coverage if You are not working are explained below.

Disability

If You become unable to perform the major duties of Your job and stop working, You can keep this coverage until 6 months from the date you stopped working due to the disability.

We may periodically require proof that You remain disabled and under the care of a physician. This proof must be given to Us within 30 days of the date We request it.

Military Leave of Absence

If you take a miliary Leave of Absence that has been approved by Your Policyholder You can keep this coverage until 12 months from the date Your leave of absence begins.

Sabbatical

This is a leave of absence during which You remain an employee of the Policyholder but do not perform Your regular job responsibilities. During this period, You must be engaged in training or studying to acquire new skills.

If You take a sabbatical approved by Your Policyholder, You can keep this coverage until 3 months from the date Your sabbatical begins.

Temporary Layoff

If You are temporarily laid off by Your Policyholder, You can keep this coverage until 3 months from the date Your Layoff begins.

Reduction in hours

If Your hours are temporarily reduced to less than the minimum required to be eligible for this coverage, You can keep this coverage until 3 months from the date the reduction in hours begins.

Temporary leave of absence

When You take a leave of absence approved by Your Policyholder, You can keep this coverage until 3 months from the date Your leave of absence begins.

If You return to work before Your coverage ends as explained above, Your coverage will continue for as long as You remain eligible.

Labor Dispute
If you are not in Active Employment due to a labor dispute and all premium is paid when due, including any portion of the premium otherwise paid by your Policyholder, you can keep this coverage until the period of time when your business activities have ceased due to the labor dispute, but not longer than 6 months after the cessation of work.

Family Medical Leave of Absence (FMLA)
Your Policyholder has established a family and medical leave policy in compliance with the Federal Family and Medical Leave Act of 1993 (FMLA) and other legally mandated leave of absence or similar laws. You should contact the Policyholder to determine eligibility and the terms, conditions and cost for continuation of insurance during a leave.

PORTABILITY COVERAGE: You may elect to continue coverage when Your coverage ends under the Policy. The terms, conditions, and premium rates of the portability coverage may be governed by a separate portability policy and may not be the same as those under this Certificate.

If You are age 70 or younger at the time Your coverage ends, You may request portability coverage for You and any covered Dependent(s) when:

1. You are no longer eligible for coverage under the Policy;
2. You are no longer employed by the Policyholder; or
3. the Policy terminates and You do not elect replacement coverage through the Policyholder's relationship with another insurance carrier.

If You are eligible to request portability coverage, then You must elect to continue insurance under this portability provision in order for any Dependent(s) to be eligible for portability coverage.

ELECTING PORTABILITY: To elect portability coverage, You must send a request to Us or the Policy Administrator. The benefits and premium rates of the portability coverage can be obtained by contacting Us or the Policy Administrator.

The request and the initial premium due must be received within 31 days after insurance under the Policy ends. If timely notice is not given, an extension of the period of time in which to request portability coverage will be allowed. You will have 15 days from the date notice is received to submit a portability request and initial premium. However, in no event will a request be accepted by Us if received more than 91 days after the date coverage under the Policy would otherwise end.

TERMINATION OF PORTABILITY: Portability coverage for You ends on the earliest of:

1. the day following the last day of a Grace Period, if full payment for Your coverage is not made within that Grace Period;

2. the date the Policy terminates;
3. Your death; or
4. the last day of the month during which; the date You attain age 70.

Portability coverage for a Dependent ends on the earliest of:

1. the termination date of Your portability coverage;
2. upon death of the Dependent;
3. the last day of the month during which a Dependent is no longer eligible for coverage due to a change to the Policy; or
4. the last day of the month during which a Dependent no longer satisfies the definition of a Spouse or Dependent child.

Coverage will end for each Dependent as of the date they no longer qualify as a Dependent as defined in this Certificate. You are responsible for notifying Us of any change in Dependent status. Our sole liability once notified is the refund of any unearned premium for the time period for which they no longer qualified as a Dependent.

Termination will not affect a claim that occurred while an Insured was covered by the Policy.

SECTION 7 – CLAIMS

NOTICE OF CLAIM: We must receive written or electronic notice of claim within 90 days after the occurrence or start of any loss covered by the Policy, or as soon as reasonably possible. Notice given by or on behalf of an Insured to Our Claims Office with information sufficient to identify the Insured, shall be deemed notice to Us. Failure to give notice within this time frame will not invalidate nor reduce any claim.

CLAIM FORMS: When We receive notice of claim, We will send the applicable claim forms to the claimant or to the Policyholder for delivery to the claimant. If these forms are not sent within 15 days, Proof of Loss may be submitted by giving Us a written or electronic statement of the nature and extent of the loss.

PROOF OF LOSS: Proof of Loss must be provided by You to Our Claims Office within 90 days after the date of the loss. However, after the 90 days, the claim will not be reduced or denied if:

1. it was not reasonably possible to give proof in that time; and
2. the Proof of Loss is filed as soon as reasonably possible.

Unless the claimant is legally incapacitated, Proof of Loss may not be given later than 12 months after the date Proof of Loss is otherwise required.

Proof of Loss must include, but may not be limited to, the following documentation:

1. a Physician's statement;
2. a completed claim form;
3. the explanation of benefits showing the services rendered;
4. an itemized bill – which must contain the claimant's name, date of service, procedure and diagnosis codes, place of service, and charge amount.

If the Proof of Loss is not complete, We will request additional information.

TIME OF PAYMENT OF CLAIMS: All benefits will be paid within 30 days, or as soon as reasonably possible, but not later than 60 days, after We receive sufficient Proof of Loss.

PAYMENT OF CLAIMS: Benefits payable under the Policy will be paid to You or to the providers of services and supplies, if You so direct electronically or in writing. Any unassigned benefits that have not been paid at the time of Your death will be paid to Your designated beneficiary or the beneficiary's assignee, if living, or to the contingent beneficiary. If no such designation is made, or in the event of death of the beneficiary, beneficiary's assignee, and contingent beneficiary, benefits will be paid to Your estate. If benefits are payable to Your estate or to any person who is not competent to give Us a valid release, We have the right to pay up to $1,000 of those benefits to any person related

to You by blood or marriage who We believe is justly entitled to such payment.

PAYMENT TO TEXAS HEALTH AND HUMAN SERVICES COMMISSION: Upon Our receipt of written notice at Our Home Office, benefits payable on behalf of a Dependent Child must be paid to the Texas Health and Human Services Commission if:

1. You are required to pay child support by a court order or court-approved agreement and:
   a. are a possessory conservator of the child under a court order issued in this state; or
   b. are not entitled to possession of or access to the child.
2. the Texas Health and Human Services Commission is paying benefits on behalf of the child under Chapter 31 or 32, Human Resources Code; and
3. the written notice specifies that the benefits must be paid directly to the Texas Health and Human Services Commission.

PAYMENT TO CONSERVATOR OF DEPENDENT CHILD: Upon Our receipt of written notice at Our Home Office, benefits payable on behalf of a Dependent Child will be paid to a person who, by court order issued in this state or another state, is appointed as the possessory or managing conservator of such Dependent Child. The conservator must submit to Us:

1. a proper claim form;
2. written notice that the person is a possessory or managing conservator of the Dependent Child on whose behalf the claim is made; and
3. a certified copy of the court order designating the person as possessory or managing conservator of the Dependent Child or other evidence designated by rule of the State Department of Insurance that the person is eligible for the benefits.

PHYSICAL EXAMINATION AND AUTOPSY: By making a claim, You or the Insured on whose behalf the claim is made must submit to a physical examination, or in the case of the Insured's death, an autopsy, as often as We may reasonably request, and in accordance with the law of the governing jurisdiction. We will pay for such examinations.

LEGAL ACTION: No legal action can be taken to receive benefits under the Policy less than 60 days after written proof of loss has been furnished as required or more than 3 years after written proof of loss is required to be furnished.

OVERPAYMENT RECOVERY: We have the right to recover from You or the recipient of benefits any amount that We determine to be an overpayment. You or the recipient of benefits has the obligation to refund to Us any such amount. If benefits are overpaid on any claim, You or the recipient of benefits must reimburse Us within 90 days.

SECTION 8 – GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The Policy, the Policyholder's Application, Your enrollment form, this Certificate, and any attached riders or endorsements make up the entire contract of insurance between the Policyholder and Us. No change shall be valid until approved by Our executive officer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

STATEMENTS: In the absence of fraud, all statements made by the Policyholder or any Insured are representations and not warranties. No such statements will be used to void the insurance, reduce benefits, or defend a claim under the Policy unless the statement is in writing; and a copy of that statement is given to You, Your beneficiary, or Your personal representative.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the Insured's effective date of coverage, no misstatement made in the enrollment form, except fraudulent misstatements, will be used to void this Certificate or deny a claim for any loss commencing after the end of the two year period. However, this shall not preclude Us at any time from asserting defenses based on an Insured's eligibility for coverage under this Policy, or upon other provisions in the Policy.

UNPAID PREMIUM: Upon the payment of a claim, any premium then due and unpaid may be deducted from the claim payment.

REINSTATEMENT: After the Insured's Certificate has lapsed, it may be reinstated only if:

1. the Policy is still in force;
2. the Insured is a member of an Eligible Class as defined in this Certificate; and
3. premium payments resume for a due date that is within six months of the Certificate's lapse date.

Our acceptance and application of resumed premium payment will activate reinstatement of the Certificate. The Certificate reinstatement date will be the first day of the premium due period for which the Policyholder paid group premiums and the Insured's resumed payment was included. The reinstated Certificate will cover only loss as defined in the Policy/Certificate that is incurred after the reinstatement date. The Insured and We will have the same rights as before termination, and all other terms of the Policy remain unchanged. All benefits previously paid within the same Plan Year as the reinstatement will count towards any benefit maximum.

MISSTATEMENT OF AGE: If the age of any Insured has been misstated, premiums may be adjusted and all benefit amounts payable shall be such as the premium paid would have purchased at the correct age. If We have accepted a premium on behalf of an Insured for a period after the date when coverage should have ended, We will refund any such premium, but We will not pay any claims for services the person received after coverage should have ended.

CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of the Certificate, which, on its effective date, is in conflict with the law of the governing jurisdiction on such date is hereby amended to conform to the minimum requirements of such law.

TIME PERIODS: Unless otherwise specifically stated, all time periods begin and end at 12:01 A.M., Standard Time at the place where the Policy is delivered.

NON-DUPLICATION OF BENEFITS: Duplication of benefits is not allowed under the Policy and any attached riders. If a covered charge is payable under more than one benefit, only one benefit, the largest, will be payable.

SECTION 9 - TERMINATION OF COVERAGE

TERMINATION:
Subject to the Portability coverage Provision, Your coverage will end at 11:59 PM PST on the earliest of the following:

1. The date You are no longer eligible under this Certificate;
2. The date this coverage is no longer available to the class of Members to which You belong;
3. The last day of the period for which the required premiums have been paid;
4. The day You reach age 80;
5. The day You die; or
6. The day the Policy ends.

Coverage for Your Dependent will end at 11:59 PM PST on the earliest of the following:

1. The date Your coverage ends;
2. The date You stop being a member of a class that's eligible for Dependent coverage;
3. The last day of the period for which the required premiums were paid;
4. For a Spouse, the date Your marriage ends in divorce or annulment or Your civil union or domestic partnership is dissolved;
5. For a Spouse, the date your Spouse reaches the maximum age;
6. For a child, the date Your child reaches the maximum age or no longer meets the conditions listed under definition of Dependent(s);
7. For a child, the date Your child marries or enters into a domestic partnership;
8. The date the Dependent becomes ineligible as defined in this Certificate; or
9. The date the Dependent dies.

You are responsible for notifying Us of any change in Dependent status. Our sole liability once notified is the refund of any unearned premium for the time period for which they no longer qualified as a Dependent.

Any unearned premium created by a termination of coverage will be promptly returned.

Termination will not affect a claim that occurred while an Insured was covered by the Policy.

EXTENSION OF BENEFITS: If coverage ends while an Insured is Confined to a Hospital as an Inpatient as the result of a Covered Accident or Covered Sickness, or is Disabled as the result of a Covered Accident or Covered Sickness, We will continue to pay benefits for that Insured until the earliest of:

1. 90 days after the coverage ended;
2. the date the Insured is no longer Confined to a Hospital as an Inpatient or Disabled; or
3. the date the Insured receives the maximum benefits available under the Policy.

SECTION 10 - DEFINITIONS

The following section defines some important terms that may be applicable to the coverage. **These are only definitions and not indicative of coverage**. Please review the Benefits section of this Certificate, any attached rider, and the Certificate Schedule for specific coverage.

ACTIVE EMPLOYMENT, ACTIVELY EMPLOYED: You are working for earnings for the Policyholder that are paid regularly and are performing the material and substantial duties of Your Regular Occupation. You must be regularly scheduled to work at least the minimum number of hours as determined by the Policyholder.

Your work for the Policyholder must be performed at:

1. the Policyholder's usual place of business in the United States;
2. an alternative work site at the direction of the Policyholder;
3. or a location in the United States to which Your job requires You to travel.

Normal vacation and holidays are considered Active Employment provided You are in Active Employment on the last scheduled workday preceding such time off.

For purposes of this certificate, temporary business closures that meet the definition of Active Employment include, but are not limited to:
1. inclement weather;
2. power outage; and
3. public health agency orders.

Temporary and seasonal workers are excluded from coverage.

AMBULATORY SURGICAL CENTER: A licensed healthcare facility, separate from a Hospital, equipped for Physicians to perform Surgeries on an individual as an Outpatient. An Ambulatory Surgical Center must:

1. be under the direct supervision of a Physician;
2. provide anesthesia administered by a licensed anesthesiologist or licensed Nurse anesthetist; and have agreements in place with one or more local Hospitals to immediately accept patients who develop complications.

BEHAVIORAL HEALTH PROFESSIONAL: A person who is appropriately licensed by the jurisdiction in which Treatment is rendered to clinically diagnose, prescribe medication, or provide professional counseling for Mental or Nervous Disorders Substance Abuse and who is acting within the scope of his/her license, relevant board certifications, and qualifications.

CALENDAR YEAR: The time period commencing on January 1st and ending December 31st of the same year.

CERTIFICATE: This document, which explains the insurance benefits provided, to whom and how benefits are payable, and limitations as well as exclusions that apply to coverage.

CHILDBIRTH: Birth of a child by routine vaginal delivery or elective cesarean section.

CHIROPRACTIC THERAPY: Spinal manipulation services conducted by a licensed chiropractor to correct a structural imbalance. For purposes of this Certificate, the following services do not meet the definition of Chiropractic Therapy:

1. massage therapy;
2. Treatment of chronic conditions; and
3. other injuries related to structural imbalance.

CHIROPRACTOR: An individual licensed by the Texas Board of Chiropractic Examiners.

CLAIMS OFFICE: Pacific Life & Annuity Company PO Box 2387, Omaha, NE 68103.

COMPLICATION(S) OF PREGNANCY: Abnormal condition or concurrent disease, whether or not a pregnancy is terminated, that significantly affects the pregnancy's usual medical management. A complication may exist during the pregnancy, during the birth, or after the birth. Complication of Pregnancy includes non-elective cesarean section.

Complication of Pregnancy does not include: elective caesarean section unrelated to a diagnosed Complication of Pregnancy; false labor; morning sickness; multiple gestation pregnancy; occasional spotting; Physician prescribed rest during pregnancy; pre-eclampsia; any similar condition(s) associated with a difficult pregnancy but not considered a classifiable, distinct Complication of Pregnancy; or any other condition associated with pregnancy but has not been diagnosed by a Physician as a Complication of Pregnancy as defined.

CONFINED, CONFINEMENT: Assignment to a bed in a medical facility for a period of at least 12 consecutive hours.

COVERED ACCIDENT: A sudden, unforeseeable, and unexpected event that causes Injury to an Insured, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition. A Covered Accident must occur while the Insured is covered under this Certificate and must not be excluded or limited by name, description, or any other provision of this Certificate.

COVERED SICKNESS: An illness which:

1. occurs while coverage is inforce under this Certificate for the Insured;
2. is diagnosed by a Physician, or Medical Professional, or Behavioral Health Professional; and
3. is not excluded or limited by name, description, or any other provision of this Certificate.

Complication of Pregnancy or Childbirth will be treated as any other Covered Sickness. Covered Sickness will also include any prenatal diagnosis of a Sickness for a newborn.

DEPENDENT(S): Any person who is:

1. Your Spouse; or
2. Your or Your Spouse's child, who is:
   i. Unmarried;
   ii. Under the age of 26.

Your child is one of the following:
1. Your biological child;
2. Your stepchild;
3. A child placed with You or Your Spouse for adoption, including where You or Your Spouse are a party to a suit in which You or Your Spouse seek to adopt the child, or foster care;
4. Your grandchild who You declare as a Dependent on Your federal income taxes;
5. A child for whom You must provide medical or dental support regardless of whether the child resides with You; or
6. A child for whom You have been appointed a legal guardian and who You claim as a Dependent on Your federal income taxes.

A child may keep this coverage past the age limit if the child is all the following:
1. Unable to live independently due to a mental, physical, or developmental disability which began before reaching the maximum age;
2. Primarily dependent upon You for financial support;
3. Not married or in a domestic partnership; or
4. Continuously covered by the Policy, or by the group Policy the Policy replaced, through the time the maximum age was reached.

You will have to send Us proof that Your child meets these requirements within 31 days of the date the maximum age was reached.

After two years have passed from the date the maximum age was reached, We may periodically ask for documentation that Your child continues to meet these requirements. We will not ask for this more than once a year.

Coverage extended in accordance with this section will end when Your child no longer meets the conditions above. Even when Your child does meet the requirements listed above, this coverage can end due to any of the reasons, other than reaching the maximum age, listed under the When family coverage ends section.

DEPENDENT ADULT CARE: Care provided on a regular basis for daily periods of less than 24 hours (whether daytime or nighttime hours) for a mentally or physically Disabled adult Family Member who is living with an Insured and is dependent on the Insured for support and maintenance.

DEPENDENT ADULT CARE CENTER: An appropriately licensed Dependent Adult Care provider or facility that provides care for Disabled adults in a group setting.

DEPENDENT CHILD CARE: Care provided for a Dependent Child under the age of 16 on a regular basis for daily periods of less than 24 hours (whether daytime or nighttime hours).

DEPENDENT CHILD CARE CENTER: An appropriately licensed Dependent Child Care provider or facility that provides care for children in a group setting.

DISABLED, DISABILITY: Unable, because of an injury or sickness, to perform the material and substantial duties of any occupation for which one is qualified by reason of education, experience, or training.

DOULA: A trained companion employed to provide mental, physical, and emotional guidance and support to an expectant mother during and after Childbirth. The Doula must be acting within the scope of their training. A doula does not include an Insured or Family Member.

EMERGENCY CARE: Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected 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.

Emergency Care is a covered service. The benefit payable may vary by the place of service.

EMERGENCY ROOM: A specified area within a Hospital, or standalone facility that is affiliated with a Hospital, designated for the Emergency Care of accidental injuries or sicknesses. This area must:

1. be staffed and equipped to handle trauma;
2. be supervised and have Treatment provided by Physicians; and
3. provide care seven days per week, 24 hours per day.

EMPLOYEE: A person, also referred to as "You," who is Actively Employed.

EMPLOYER: The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employee's premium is being paid.

ENROLLMENT PERIOD: A time period determined by Employer and Us during which You are eligible to enroll for or change Your coverage. This time period may be limited.

ENROLLMENT PERIOD EFFECTIVE DATE: A date determined by the Policyholder and Us upon which coverage will begin or change when You elect to enroll in or change coverage during an Enrollment Period. There may be a time period following the end of the Enrollment Period and the Enrollment Period Effective Date during which You will not be covered.

EVIDENCE OF INSURABILITY: Documentation and/or attestations supplied by You and reviewed by Us used to determine whether a person can be an Insured under this Certificate.

FAMILY MEMBER: An Insured's Spouse (current and former); domestic partner (or equivalent); child; sibling; parent; grandparent; grandchild; aunt; uncle; first cousin; nephew; niece; or the spouse or domestic partner (or equivalent) of such individuals. This includes adopted, in-law and step-relatives, and anyone living in the Insured's household.

GENERAL ANESTHESIA: The induction of a balanced state of unconsciousness, accompanied by the absence of pain sensation and the paralysis of skeletal muscle over the entire body. General Anesthesia does not include epidural anesthesia, peripheral nerve blocks, or local anesthesia.

HOME HEALTH CARE: Healthcare services provided by a Home Health Care Agency in the residence of an Insured, including, but not limited to, counseling services, home health aide services, Hospice Care, skilled nursing care, medical social services, and Physical Therapy. Services must be rendered under a plan of care that is established and reviewed regularly by a Physician.

HOME HEALTH CARE AGENCY: An appropriately licensed Home Health Care Agency which:

1. is primarily engaged in providing Home Health Care;
2. provides services under the supervision of a Physician or Medical Professional;
3. has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4. maintains clinical records on all patients.

HOME OFFICE: Pacific Life & Annuity Company P.O. Box 2387, Omaha, NE 68103.

HOSPICE CARE: Specialized care, medical services, and emotional support for an Insured who is in the last stages of a terminal condition, with less than six months to live if the condition runs its normal course, focusing on comfort and quality of life rather than recovery.

HOSPICE FACILITY: An appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1. provides Hospice Care and related services 24 hours per day, 7 days per week;
2. is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times; and
3. is not mainly a place for care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental or Nervous Disorders, or a hotel or similar establishment.

Confinement in a Hospice Facility must follow certification by a Physician or hospice medical director that an Insured is terminally ill with less than six months to live if the Sickness runs its normal course. This definition does not include a nursing home, Rehabilitation Unit, Skilled Nursing Facility, or swing bed hospital authorized to provide, and be paid for, extended care services.

HOSPITAL(S): A medical facility that:

1. is licensed and operated pursuant to law in the jurisdiction where the Hospital is located;
2. provides care and Treatment for ill and injured persons on an Inpatient basis;
3. provides facilities for medical, diagnostic, and surgical care (which facilities need not be at the Hospital. They may be elsewhere if there is a formal agreement for their use);
4. provides 24 hour per day nursing care by or under the supervision of a registered Nurse (RN);
5. is supervised by a staff of one or more Physicians; and
6. is accredited by the Joint Commission on the Accreditation of Hospitals.

A Hospital is not an institution, or part thereof, used as: a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a Hospice Facility, a Substance Abuse Facility a Mental and Nervous Disorder Facility, a long-term nursing unit or geriatrics ward, or an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

INJURY, INJURIES: Any damage or harm to the body that is the direct result of a Covered Accident and not related to any other cause.

All Injuries sustained in one accident, including all related conditions and recurring symptoms of the Injuries, are considered one Injury.

INPATIENT: An Insured who is Confined and charged at least one day's room and board by a Hospital. The requirement that an Insured be charged by the Hospital does not apply to Confinement in a Veteran's Administration (VA) Hospital or other federal government Hospital.

INSURED: Any person who has coverage under the Policy and this Certificate.

INTENSIVE CARE UNIT (ICU): A specifically designated area of the Hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care. The Intensive Care Unit (ICU) must:

1. be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient Confinement;
2. be permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
3. be under close observation by a specially trained nursing staff assigned exclusively to the ICU on a 24-hour basis; and
4. have a Physician assigned to the ICU on a full-time basis.

An Intensive Care Unit may include Hospital units with the following (or similar) names: burn unit; critical care unit; neonatal intensive care unit; or transplant unit.

An Intensive Care Unit is not any of the following step-down units: intermediate care unit; modified/moderate care unit; observation unit; progressive care unit; or sub-acute intensive care unit.

Intensive Care Unit does not include a private monitored room.

INVASIVE DIAGNOSTIC EXAM: A biopsy, colonoscopy, endoscopy, ultrasound, venography, arthroscopy, bronchoscopy, cystoscopy, esophagoscopy, gastroscopy, laparoscopy, tracheoscopy, laryngoscopy, and proctosigmoidoscopy.

LAB TEST(S): A laboratory study of human blood, bodily tissues, or fluids, such as a blood chemistry or urinalysis. This definition does not include a Major Diagnostic Exam or X-Ray.

LAYOFF: A temporary absence from Active Employment for a period of time that has been agreed to in advance by Your Employer.

LEAVE OF ABSENCE: A temporary absence from Active Employment for a period of time under a leave granted in writing by Your Employer that is in accordance with Your Employer's formal leave policies.

LODGING: An appropriately licensed establishment, such as a hotel, inn, lodge, motel, or other facility that provides sleeping accommodations to the general public in exchange for a fee.

MAJOR DIAGNOSTIC EXAM: Electroencephalogram (EEG) tests and Computerized Tomography (CT or CAT), Magnetic Resonance Imaging (MRI), Single-Photon Emission Computed Tomography (SPECT), or Positron Emission Tomography (PET) scans. This definition does not include any Lab Test or X-Ray.

MASTER APPLICATION: The document signed by the Policyholder that contains the answers to our questions and are the Policyholder's representations, which We accepted in good faith as being true, complete, and correct. The Master Application is the basis upon which We issued the Policy.

MEDICAL APPLIANCE(S): A wheelchair, motorized scooter, walker, walking boot, or any other medical device used for mobility including a brace, cane, and crutches.

MEDICAL PROFESSIONAL: A person who is not a Physician but is appropriately licensed to provide some medical care and Treatment, including a Nurse practitioner (NP/APRN), physician's assistant (PA), or registered Nurse (RN). The Medical Professional must be acting within the scope of his/her license, relevant board certifications, and qualifications in the jurisdiction which issued their license. If required by law, the Medical Professional must be under the supervision of a Physician.

MEDICALLY NECESSARY: A Treatment, service, or supply which is broadly accepted by the medical profession as appropriate and essential in the diagnosis or Treatment of an Injury or sickness and is based on generally recognized and accepted standards of health care. A determination of whether Treatment is Medically Necessary must be made by a Physician acting within the scope of his/her license, relevant board certifications, and qualifications in the jurisdiction which issued their license. Determinations of Medical Necessity are made by an Insured's provider and not by Us.

MENTAL OR NERVOUS DISORDER(S): A psychiatric or psychological condition classified in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM) published by the American Psychiatric Association (APA), as of the date such condition is diagnosed. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the APA as of the date such condition is diagnosed. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, we will use a comparable diagnostic manual.

This definition does not include conditions, diseases, or disorders for which the primary diagnosis is attributable to Substance Abuse.

MENTAL & NERVOUS DISORDERS FACILITY: An appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1. specializes in psychiatric care for Mental or Nervous Disorders;
2. is under the direct supervision of a Physician;
3. has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4. is not mainly a place for rest, custodial care, care of the aged/elderly, care of persons with

Substance Abuse disorders/issues, or a hotel or similar establishment.

Confinement in a Mental and Nervous Disorders Facility must be at the direction of a Physician.

NURSE(S): A healthcare professional trained to care for people with injuries or sicknesses. A Nurse may include a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

OBSERVATION UNIT: A specified area within a Hospital, separate from the Emergency Room, where a patient can be monitored following a Surgery performed as an Outpatient or Treatment in the Emergency Room. The Observation Unit must:

1. be under the direct supervision of a Physician or registered Nurse;
2. be staffed by Nurses assigned specifically to that unit; and
3. provide care seven days per week, 24 hours a day.

OBSERVATION UNIT LONG STAY: Continuous Treatment of an Insured within an Observation Unit for a time period that is 24 hours or longer.

OBSERVATION UNIT SHORT STAY: Continuous Treatment of an Insured within an Observation Unit for a time period that is less than 24 hours.

OCCUPATIONAL THERAPIST: A healthcare professional licensed to practice Occupational Therapy in the jurisdiction in which Treatment is rendered, who:

1. performs services which are allowed by their license;
2. performs services for which benefits are provided by this certificate; and
3. possesses the designation “Occupational Therapist Registered” (OTR).

An Occupational Therapist does not include an Insured or a Family Member.

OCCUPATIONAL THERAPY: TheTreatment of a physically Disabled person by means of constructive activities designed and adapted to promote the restoration of the person’s ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person’s particular occupational role. Occupational Therapy does not include:

1. diversional therapy;
2. recreational therapy; or
3. any vocational therapies (e.g. hobbies, arts, and crafts).

ON THE JOB INJURY: An Injury which is sustained during an Insured’s working for pay or profit.

ORGANIZED SPORT(S): Amateur athletic events governed by written rules, with paid referees, and which are sponsored by an organization or club with by-laws.

OUTPATIENT: An Insured who receives Treatment or services at a Hospital, Ambulatory Surgery Center, lab, medical clinic, Physician's or Medical Professional's office/clinic, radiologic center or other licensed medical facility and is neither Confined nor charged for room and board.

OUTPATIENT THERAPY INFUSION CENTER: An appropriately licensed Infusion Therapy Center which:

1. is primarily engaged in providing infusion therapy intravenously;
2. provides services under the supervision of a Physician or Medical Professional; and
3. maintains clinical records on all patients.

PACIFIC LIFE & ANNUITY COMPANY: Referred to as "Pacific Life," "We," "Us," or "Our."

PET BOARDING FACILITY: An appropriately licensed independent animal care provider or facility specializing in the care and overnight boarding of animals that is not owned or operated by an Insured or a Family Member.

PHYSICAL THERAPIST: A healthcare professional licensed to practice Physical Therapy in the jurisdiction in which Treatment is rendered, who:

1. performs services which are allowed by their license; and
2. practices according to the Code of Ethics of the American Physical Therapy Association.

PHYSICAL THERAPY: Treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical, and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent Disability following Injury.

PHYSICIAN(S): A person who is operating within the scope of their active medical license within the jurisdiction which issued the license, relevant board certifications, qualifications, and is also:

1. a legally licensed and qualified medical practitioner as a doctor of medicine according to the laws of the governing jurisdiction in which Treatment is received; and
2. licensed to practice medicine, prescribe and administer drugs, or to perform surgery.

PLAN YEAR: The time period commencing on the Policy Effective Date and ending the day before the next succeeding Policy Anniversary and thereafter, each 12-month period commencing on the Policy Anniversary.

POLICY: The Policy issued to the Policyholder under which this Certificate was issued.

POLICYHOLDER: The legal entity to which the Policy is issued.

PRE-EXISTING CONDITION: A disease or physical condition for which, during the months immediately preceding the Insured's Effective Date:

1. Treatment was received or recommended by a Physician, or Medical Professional, or Behavioral Health Professional; or
2. Prescription Drugs were taken.

PRESCRIPTION DRUG: A pharmaceutical substance that legally requires a medical prescription to be dispensed. This definition does not include:

1. any drug that is available over the counter or for which a suitable equivalent drug is available over the counter;
2. any drug which has not been approved by the U.S. Federal Drug Administration (FDA) for use in Treatment of an Insured's Injury, symptoms, or other condition; or
3. immunizations.

PRIMARY INSURED, YOU, YOUR: An Employee who is currently covered under the Policy and this Certificate, and not a covered Dependent or Spouse of another Insured under the Policy and this Certificate.

QUALIFYING LIFE EVENT: One of the following events:

1. You get married, or enter into a relationship with someone who satisfies the definition of Spouse;
2. You and Your Spouse divorce or legally terminate Your relationship;
3. Your Spouse dies;
4. You acquire a child who satisfies the definition of a Dependent;
5. Your Dependent no longer satisfies the definition of a Dependent or dies;
6. Your Spouse loses eligibility for themselves, You, or a Dependent under another employer sponsored accident and/or sickness insurance plan;
7. You change job role, employment classification, or the number of scheduled hours per week but are still eligible for coverage under this Policy.

REGULAR OCCUPATION: The occupation You are routinely performing. We will look at Your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer at a specific location.

REHABILITATION CARE SERVICES: Coordinated multidisciplinary physical restorative services (the combined use of medical, social, educational and vocational services) to enable an Insured who has experienced a disabling Covered Accident to achieve the highest possible functional ability.

REHABILITATION THERAPIST: A healthcare professional licensed by the Situs State to practice Physical Therapy, Occupational Therapy, speech therapy, or cognitive-behavioral therapy and who:

1. practices according to the Code of Ethics of the American Physical Therapy Association;
2. possesses the designation "Occupational Therapist Registered" (OTR);
3. is licensed as a Speech-Language Pathologist; or
4. is a Physician board-certified through the American Board of Professional Psychology.

REHABILITATION THERAPY: Physical Therapy, Occupational Therapy, speech therapy, and/or cognitive-behavioral therapy provided by a Rehabilitation Therapist within the scope of their license.

REHABILITATION UNIT: An appropriately licensed standalone healthcare facility, or a distinct unit within a Hospital, that provides Rehabilitation Care Services on an Inpatient basis and at the direction of a Physician. The Rehabilitation Care Services provided by the Rehabilitation Unit must:

1. consist of the combined use of medical, social, educational, and vocational services to enable patients Disabled by Injury or sickness to achieve the highest possible functional ability;
2. be provided under a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
3. be provided by or under the supervision of an organized staff of Physicians.

The following do not meet the definition of Rehabilitation Unit:

1. a nursing home, rest home, convalescent home, home for the aged, or an assisted living facility;
2. a facility which primarily provides Hospice Care; and
3. facilities or a wing/ward of a Hospital primarily for the care and Treatment of persons with Substance Abuse issues/disorders or Mental or Nervous Disorder(s).

SKILLED NURSING FACILITY: An appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1. provides skilled nursing care and related services 24 hours per day, 7 days per week;
2. is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times;
3. has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4. is not mainly a place for rest, custodial care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental or Nervous Disorders, or a hotel or similar establishment.

Confinement in a Skilled Nursing Facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Rehabilitation Unit, or swing bed hospital authorized to provide, and be paid for, extended care services.

SPOUSE: The person to whom You are legally married, Your civil union partner, or Your domestic partner.

Your domestic partner is the person of the same or different sex with whom you live and share financial assets and obligations. Your domestic partner must be able to provide legal consent and cannot be a blood relative. You and Your domestic partner may not be married to, in a domestic partnership with, or legally separated from anyone else.

Your domestic partnership must be registered with a state or local government registry.

We will not require proof of registered domestic partnership that we wouldn't require of a marriage.

We may require proof of an unregistered domestic partnership.

SUBSTANCE ABUSE: A mental health disorder defined as a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress. Substance Abuse must meet the criteria for Substance Use Disorder in the current Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA).

If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the APA as of the date such condition is diagnosed. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, we will use a comparable diagnostic manual.

SUBSTANCE ABUSE FACILITY: An appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1. specializes in habilitation, rehabilitation, Treatment, and related services for persons with chemical dependencies resulting from Substance Abuse;
2. is under the direct supervision of a Physician;
3. has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4. is not mainly a place for rest, custodial care, care of the aged/elderly, care of persons with Mental or Nervous Disorders, or a hotel or similar establishment.

Confinement in a Substance Abuse Facility must be at the direction of a Physician.

SURGERY, SURGERIES: A medical procedure requiring an incision and manipulation (typically with instruments) performed on a person's body to repair an Injury. Two or more surgical procedures through the same incision or entry point are considered one Surgery.

TELEMEDICINE: The remote diagnosis and/or Treatment of an Insured's Injury by a Physician using telecommunications technology.

TREATMENT(S): Medical advice, diagnosis, care, or services (including diagnostic measures and prescription drugs) rendered to an Insured by a Physician or Medical Professional operating within the scope of their active license to practice medicine in the jurisdiction where services are rendered.

URGENT CARE FACILITY: A licensed, freestanding healthcare facility providing immediate, short-term medical care without an appointment, other than a Hospital (including any Outpatient department of a Hospital), Emergency Room, Physician's office, or Medical Professional's office/clinic. The facility must:

1. be under the direct supervision of a Physician; and
2. provide Treatment by Physicians and/or Medical Professionals.

WE, US, OUR: Pacific Life & Annuity Company

WELLNESS TEST: Any of the following:

1. abdominal aortic aneurysm ultrasonography;
2. biopsies for cancer;
3. blood test for lipids including total cholesterol, LDL, HDL, and triglycerides;
4. bone marrow testing;
5. bone density screening;
6. CA15-3 blood test for breast cancer;
7. CA 125 blood test for ovarian cancer;
8. cancer genetic mutation test (BRCA);
9. carotid doppler;
10. CEA blood test for colon cancer;
11. chest x-ray;
12. colonoscopy;
13. CT angiography;
14. double contrast barium enema;
15. electrocardiogram;
16. fasting blood glucose test;
17. flexible sigmoidoscopy;
18. hemoccult stool analysis;
19. immunizations or vaccinations;

20. Lymphocyte Genome Sensitivity Test (LGS) (universal blood test for cancer);
21. pap smear (including ThinPrep);
22. PSA test;
23. serum cholesterol test to determine level of HDL and LDL;
24. serum protein electrophoresis (blood test for myeloma);
25. skin cancer screening;
26. stress test;
27. testicular ultrasound;
28. thermography;
29. smoking cessation program; or
30. weight reduction program.

X-RAY(S): A form of electromagnetic radiation that passes through structures within the body and results in images of the structures. This definition does not include a Major Diagnostic Exam or Lab Test.