Office of the Administrator
P.O. Box 14536
Des Moines, IA 50306

Now you'll have help with the high out-of-pocket hospital costs associated with an unexpected or prolonged hospital stay thanks to the ROA Hospital Indemnity Insurance Plan.

Dear ROA Member,

Thank you for requesting information about the ROA Hospital Indemnity Insurance Plan.

Enclosed are more details, including a summary of benefits and an Enrollment Form.

Before you take a closer look at this information, here are some key highlights:

- **You, your spouse and dependent children are guaranteed acceptance*** in this plan if you're an eligible member under age 65. You can't be turned down. Simply complete and return the enclosed Enrollment Form to obtain this coverage.
- **You can choose between two DAILY hospital stay benefit plans ($100/day or $150/day** up to 90 days) that pay cash benefits directly to you to use however you need.**
- **Benefits are paid in addition to other coverage you may have.**
- **You pay an affordable group rate** based on the group buying power of the ROA membership!

ROA recognized the importance and need for this type of coverage amid today's health care environment. Here's why:

Does cancer or heart disease run in your family? Along with pneumonia and accidents, these illnesses are common causes of hospital stays. If you or a family member become ill or injured and are hospitalized, will you need help covering unexpected medical expenses that could add up to thousands of dollars in out-of-pocket costs?

(Over, please)

These out-of-pocket costs also include non-medical expenses like transportation to and from the hospital for loved ones to visit, lost income, supplies at the local pharmacy, food for your family, etc.

The ROA Hospital Indemnity Insurance Plan is designed to help by paying you cash benefits for every day you or a covered dependent are hospitalized (up to 90 days per year) - in addition to what your basic health insurance or other coverage pays.

So enroll in this coverage today. It's easy to do!

Simply complete the enclosed Enrollment Form and return it to us. Send no money now.

Once we receive your form, we'll mail your Certificate to you. You'll then have a full 30 days to review all the benefits in more detail. If you decide the ROA Hospital Indemnity Insurance Plan is for you, just send in your payment.

Thank you again for considering this valuable ROA insurance coverage. We hope you take advantage of it!

Sincerely,

Stephen Miller

Stephen Miller, Senior Vice President
Association Member Benefits Advisors, LLC
ROA Insurance Plans Administrator
License #1936106

P.S. This ROA Hospital Indemnity Insurance Plan can help pay your out-of-pocket costs related to hospital stays. The cash benefits from this plan are paid directly to you to spend however you choose. You and your family are guaranteed acceptance and cannot be turned down.* So enroll today. Just complete and return the enclosed Enrollment Form.

*This policy is guaranteed acceptance, but it does contain a Pre-Existing Conditions Limitation. Please refer to the enclosed Summary of Benefits for more information on exclusions and limitations, such as Pre-Existing Conditions.
**The benefit amount(s) payable for each covered person will decrease by 50% on the premium due date on or next following the date the member attains age 80.

Please read the enclosed Summary of Benefits for more information, including costs, exclusions, limitations, reduction of benefits and terms of coverage.

Underwritten by Hartford Life and Accident Insurance Company, Hartford, CT 06155.

AGP-40006

ROA®
RESERVE STRENGTH
RESERVE LIFE

Questions?

Call toll-free 1-800-247-7988
7:30 a.m. to 5:00 p.m. Central Time, Monday – Friday
or email us at roa.service@getamba.com or visit www.roainsure.com

Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.

ROA Hospital Indemnity Insurance Plan

Summary of Benefits

The ROA Hospital Indemnity Insurance Plan helps provide protection by paying cash benefits for every day you're hospitalized (up to 90 days per year) - in addition to what your basic health insurance or other coverage pays. It can help reduce or eliminate your out-of-pocket hospital stay expenses with cash benefits paid directly to you. You can use the cash for extra expenses your hospital stay brings, put it in savings, or toward your medical costs. The choice is yours.

Guaranteed Acceptance

Eligible ROA members under age 65 are guaranteed this coverage. Eligible members cannot be turned down. Your eligible spouse and eligible children under age 26 are also guaranteed acceptance in this plan. This policy is guaranteed acceptance, but it does contain a Pre-Existing Conditions Limitation. Please see below for more information on exclusions and limitations, such as Pre-Existing Conditions.

Choice of Benefit Plans

You select the plan that best fits your needs:

Benefits	Low Option	High Option
Day 1: First day Hospital Confinement, must begin within 90 days of covered illness or injury, paid 1x per year	$500	$1,000
Day 2+: Daily Hospital Confinement, up to 90 days per year, must begin within 90 days of covered illness or injury	$100 per day	$150 per day
Intensive Care Unit (ICU) Admission: Daily ICU Confinement, up to 30 days per year, must begin within 90 days of covered illness or injury	$200 per day	$300 per day

Eligibility

You are eligible for coverage if you are under age 65, a U.S. resident and are an active member of ROA. Your lawful spouse or Civil Union or domestic partner, not legally separated or divorced from you, not in active full-time military service, over the age of 18 but under age 65, and your dependent children, not active in full-time military service and under age 26 are also eligible.

You must be enrolled for Coverage under this Policy in order to enroll Dependent(s) for Coverage.

You may not elect coverage for your Dependent if such Dependent is covered as a Member under the Policy. No person can be insured as a Dependent of more than one Member under the Policy.

How it Works

You collect cash benefits for each day of a covered hospital stay. For the first day of your confinement, you will be paid the low or high option benefit you choose. After that, for each additional day, up to 90 days per year, you'll collect the daily benefit amount for the plan you choose.

Affordable Group Rates

Thanks to the group buying power of the entire ROA membership, you pay an economical group rate.

Low Option Plan Monthly Rates

$500 first day of confinement / $100 per day after / $200 per day for ICU

Age	Member Only	Member & Spouse	Family	Member & Child(ren)
18-24	$4.56	$18.32	$28.89	$13.35
25-29	7.14	19.38	29.71	16.18
30-34	7.74	17.80	27.96	16.81
35-39	6.40	12.83	22.84	15.28
40-44	5.44	10.89	20.89	14.12
45-49	6.56	13.08	23.08	15.19
50-54	8.57	17.14	27.14	17.13
55-59	11.28	22.62	32.62	19.78
60-64	13.23	26.53	36.52	21.72
65-69*	13.81	27.75	37.75	22.31
70-74*	14.40	28.96	38.97	22.89
75-79*	9.27	19.42	23.59	13.50
80-84*†	12.97	26.03	31.03	17.16

High Option Plan Monthly Rates

$1,000 first day of confinement / $150 per day after / $300 per day for ICU

Age	Member Only	Member & Spouse	Family	Member & Child(ren)
18-24	$8.29	$33.49	$52.14	$23.79
25-29	12.91	35.32	53.53	28.84
30-34	14.00	32.27	50.17	30.00
35-39	11.52	23.14	40.76	27.17
40-44	9.76	19.56	37.16	25.05
45-49	11.71	23.36	40.95	26.91
50-54	15.21	30.43	48.02	30.29
55-59	19.93	39.97	57.56	34.88
60-64	23.09	46.30	63.88	38.04
65-69*	24.16	48.54	66.14	39.11
70-74*	25.23	50.77	68.37	40.17
75-79*	16.13	32.34	41.14	23.58
80-84*†	22.54	45.22	54.01	29.92

For your convenience, you'll be billed quarterly. If applicable, an additional $2.00 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.You cannot be singled out for a rate increase. Rates and/or benefits may be changed on a class-wide basis. Rates are based on your attained age and increase as you enter a new age category.

*Premiums for ages 65 and over are renewal premiums only.
†The benefit amount(s) payable for each covered person will decrease by 50% on the premium due date on or next following the date the member attains age 80.

When coverage begins: Your coverage is effective as of the first day of the month after the administrator receives your enrollment form and first premium payment.

Deferred Coverage Effective Date: All Coverage Effective Dates, changes in coverage effective dates, new dependent coverage effective dates and reinstatement of coverage effective dates for a member or a dependent will be deferred if on the date the member or a dependent is to become covered, he or she is confined or confined elsewhere. Such coverage will not start until the first day of the month on or next following the day after: 1) the member or the dependent is no longer confined or confined elsewhere; and 2) the member or the dependent has engaged in all of the normal and customary activities of a person of like age, gender and good health for at least 15 consecutive days. In no event will dependent insurance become effective before a member becomes insured.

When coverage ends: Your coverage remains in effect if premiums are paid, the Master Policy is in force, and you remain a member, until you reach age 85. When coverage would otherwise end, Your Spouse may be able to continue coverage and coverage for any Dependent Child(ren) under the Spouse Continuation provision. If You die while Your Spouse is covered under the Policy, Your surviving Spouse may continue: the Spouse Benefit Amount(s) in force on the date of Your death; and coverage of Your Dependent Child(ren) who were covered by the Policy on the date of Your death. We must receive Your Spouse's written request and the required premium to continue the coverage within 30 days of the Premium Due Date next following the date of Your death. Solely for the purpose of continuing his or her coverage, Your Spouse will be considered the insured person. However, Your Spouse's or any other Dependent coverage will not continue beyond: a date the coverage would otherwise have ended under the Dependent Termination of Coverage provision; or the Premium Due Date next following the date Your Spouse remarries. Dependent coverage terminates when your coverage terminates, premiums are not paid, or they cease to be eligible dependents.

Satisfaction Guaranteed: Once you receive your Certificate of Insurance, you have a full 30 days to review it. If you're not satisfied, simply return it within 30 days of receipt; premiums paid will be refunded, minus any claims paid.

Definitions

Confined or Confinement means the assignment to a bed in a medical facility for a period of at least 20 consecutive hours or being held in a Hospital for 24 consecutive hours or more.

Hospital does not include convalescent homes; convalescent, rest or nursing facilities; facilities affording primarily custodial, educational or rehabilitory care; facilities primarily for care of the aged/elderly, care of persons with substance abuse issues/ disorders, or care of persons with mental and nervous disorders; or a distinct unit within a hospital that primarily treats or is dedicated to the care of persons with substance abuse issues/ disorders or mental and nervous disorders.

Exclusions

No benefits are payable under the Policy for any Illness or Injury that results from or is caused by a Covered Person's: 1) suicide or attempted suicide, whether sane or insane, or intentional self-infliction; 2) voluntary intoxication (as defined by the law of the jurisdiction in which the Illness or Injury occurred) or while under the influence of any narcotic, drug or controlled substance, unless administered by or taken according to the instruction of a Physician or Medical Professional; 3) voluntary intoxication through use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption; 4) voluntary commission of or attempt to commit a felony, voluntary participation in illegal activities (except for misdemeanor violations), voluntary Participation in a Riot, or voluntary engagement in an illegal occupation; 5) incarceration or imprisonment following conviction for a crime; 6) travel in or descent from any vehicle or device for aviation or aerial navigation, except as a fare-paying passenger in a commercial aircraft (other than a charter airline) on a regularly scheduled passenger flight; 7) ride in or on any motor vehicle or aircraft engaged in acrobatic tricks/stunts (for motor vehicles), acrobatic/stunt flying (for aircraft), endurance tests, off-road activities (for motor vehicles), or racing; 8) participation in any organized sport in a professional or semi-professional capacity; 9) travel or activity outside the United States or Canada; or 10) active duty service or training in the military (naval force, air force or National Guard/Reserves or equivalent) for service/training extending beyond 31 days of any state, country or international organization, unless specifically allowed by a provision of this Certificate or; 11) involvement in any declared or undeclared war or act of war (not including acts of terrorism), while serving in the military or an auxiliary unit attached to the military, or working in an area of war whether voluntarily or as required by an employer. If you notify us of active duty service or training outside the continental United States, Hawaii, Puerto Rico or Alaska, we will refund any premiums paid for any period for which no coverage is provided as a result of the exclusion. In addition, we will not pay for any benefits under the policy, unless required by law for: 1) elective abortion or complications thereof; 2) artificial insemination, in vitro fertilization, test tube fertilization; 3) sterilization, tubal ligation or vasectomy, and reversal thereof; 4) aroma therapeutic, herbal therapeutic, or homeopathic services; 5) any Mental and Nervous Disorder, unless specifically allowed by a provision of this Certificate; 6) Substance Abuse, unless specifically allowed by a provision of this Certificate; 7) medical mishap or negligence on the part of any Physician, Medical Professional, or Therapist, including malpractice; 8) Confinement, Treatment, supplies or services provided by, through or, on behalf of any government agency or program; unless payment is required by a Covered person; 9) Custodial Care, unless specifically allowed by a benefit provision in this Certificate or any rider attached to the Policy (if applicable); 10) elective or cosmetic surgery or procedures, except for reconstructive surgery: incidental to or following surgery for disease, infection or trauma of the involved body part; or due to Congenital Anomaly or disease of a Dependent Child which has resulted in a functional defect; 11) dental care or Treatment, except for: a) Treatment due to an Injury to sound natural teeth within 12 months of the Accident; and 12) Treatment necessary due to congenital disease or anomaly. Congenital Anomalies of newborn and newly adopted children are not excluded if otherwise covered under the terms of the Policy.

Other Hospital Indemnity Policy Limitation (Over-Insurance Limitation)

If a covered person is insured under any other Hospital Indemnity Policy underwritten by Hartford Life and Accident Insurance Company, any claim for benefit is only payable under one policy. The covered person (or their beneficiary or estate, in the event of death) may elect under which policy benefits are payable. We will return the amount of premium paid for any Other Hospital Indemnity policy that is declined by the covered person retroactive to the later of: 1) the last date any benefit was paid for any covered person under the other Hospital Indemnity policy; or 2) the effective date of insurance for the covered person under the other Hospital Indemnity Policy.

Pre-Existing Condition Limitation:

The plan does not pay benefits for any covered illness or covered injury that results from, or is caused or contributed to by, a pre-existing condition until 12 months after a covered person is continuously insured under the Policy. A pre-existing condition limitation of 12 months will also apply to any benefit amount increase or the addition of any benefit under the Policy. If a covered person becomes confined as the result of a pre-existing condition prior to completing this 12-month limitation period, benefits will only be payable for any day of confinement that extends after the end of the limitation period. Pre-Existing Condition means any Illness or Injury for which a Covered Person received Treatment in the 12 months prior to: the date the Covered Person became insured under the Policy; or the date of any increase in benefit amounts or the addition of any benefit under the Policy.

THIS IS A HOSPITAL CONFINEMENT INDEMNITY POLICY. THE POLICY PROVIDES LIMITED BENEFITS.

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

This brochure explains the general purpose of the insurance described, but in no way changes or affects the Policy as actually issued. In the event of a discrepancy between the brochure and the policy (Master Policy AGP-40006), the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life and Accident Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder. This program may vary and may not be available to residents of all states.

Program Offered by:

AMBA

Association Member Benefits Advisors, LLC., which acts as the insurance broker for the Group Policyholder, is appointed by The Hartford, and is compensated for the placement of insurance.

In CA d/b/a Association Member Benefits & Insurance Agency
CA Insurance License #0I96562
AR Insurance License #100114462

P.O. BOX 14536
Des Moines, IA 50306

Underwritten by:

THE HARTFORD

Hartford Life and Accident Insurance Company
Hartford, CT 06155

The Hartford Financial Services Group, Inc. (NYSE: HIG) operates through its subsidiaries under the brand name, The Hartford, and is headquartered in Hartford, Connecticut. For additional details, please read The Hartford's legal notice at www.thehartford.com.

Questions About This Coverage?
Call: 1-800-247-7988
Visit: www.roainsure.com
Email: roa.service@getamba.com

AGP-40006
ROAHIPB

Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage of **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Form PA-9055

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

Reserve Organization of America

THE HARTFORD

Hospital Indemnity Insurance Plan Enrollment Form
Members ages 64 and younger
Group Policyholder: Reserve Organization of America
Policy Number: AGP-40006

SECTION 1

Member Information

Member Name:		**ROA Membership Number:**	
Street:	**City:**	**State:**	**Zip Code:**
Member Date of Birth:	**Gender:** ☐ Male ☐ Female	**Member Social Security Number:**	
Email Address:		**Preferred Phone #:**	

SECTION 2

Is Spouse coverage desired? ☐ Yes ☐ No **Spouse Gender:** ☐ Male ☐ Female

Spouse Full Name (if enrolling): **Spouse Date of Birth:**

SECTION 3

Dependent Child(ren) Information (if enrolling)		**If more than 4 child(ren), attach additional sheet.**	
Child Name	**Date of Birth**	**Child Name**	**Date of Birth**

SECTION 4

Coverage Information

☐ YES, enroll me in the Hospital Indemnity Insurance Plan. I understand I have 30 days to review my Certificate at no risk.

Age Reduction

The benefit amount(s) payable for each covered person will decrease by 50% on the premium due date on or next following the date the member attains age 80.

I hereby enroll in the following coverage (check all that apply):

LOW OPTION: Lower Benefits:
- ☐ Member Only (H051)
- ☐ Member & Spouse (H052)
- ☐ Family (H053)
- ☐ Member & Child(ren) (H054)

HIGH OPTION: Higher Benefits:
- ☐ Member Only (H101)
- ☐ Member & Spouse (H102)
- ☐ Family (H103)
- ☐ Member & Child(ren) (H104)

Is this coverage intended to replace other accident or health insurance for which you are currently enrolled?
Member: ☐ Yes ☐ No Spouse (if applying): ☐ Yes ☐ No

Mail your completed enrollment form to: **ROA GROUP INSURANCE PLAN,** P.O. BOX 14536, Des Moines, IA 50306

Questions? **CALL:** 1-800-247-7988, **EMAIL:** roa.service@getamba.com, **WEBSITE:** www.roainsure.com

Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.

SECTION 5

Authorization

I hereby confirm my enrollment in the Hospital Indemnity Insurance Plan. Please process my enrollment form and send my Certificate of Insurance immediately. I understand I must be a member of ROA to be eligible for coverage. I hereby certify that the above statements are complete and true to the best of my knowledge. I understand that this Plan will not cover pre-existing conditions (conditions for which I received medical advice or treatment within 12 months) until the coverage has been in effect for 12 months. I understand the above coverage will become effective on the first day of the month following receipt of my enrollment form and first premium payment. I further understand that new conditions will be covered immediately. I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the Affordable Care Act.

The Certificate provides limited benefits. Review your Certificate carefully.

Member Signature:	**Date:**
Spouse Signature (if enrolling):	**Date:**

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Coverage will be issued upon receipt of this form and will begin when your first premium is received. However, insurance benefits payable are subject to the policy's Pre-Existing Conditions Limitation. You're covered immediately for ALL new health conditions and any current health conditions you have will be covered fully after 12 months. Please refer to the enclosed brochure for more information on exclusions and limitations, such as pre-existing conditions.

SECTION 6

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name:	Banking Institution:	Routing Number:
Account Number:	Bank Account Type: ☐ Checking ☐ Savings	

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If your dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Member Signature:	**Date:**
Spouse Signature (if enrolling):	**Date:**

Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.