



THE TRUST *INDEMNICARE*

A Plan of Hospital Indemnity Insurance

What is it and why do I need it?

In this era of rising health care costs, a hospital stay could wind up costing you far more than your medical insurance provides. In fact, statistics show that the vast majority of individuals incur substantial charges not covered by their primary medical insurance plan for a hospital stay. And what about when you get home and can't fend for yourself and need home health care?

This insurance plan will not only help you pay for extra expenses such as special nursing charges while in the hospital, long distance telephone calls, extra hospital room and board charges which may not be covered, **but also provides for benefits while receiving home health care after you arrive home from the hospital.** Recognizing that so many surgical procedures are now being done on an outpatient basis, ***IndemniCare*** also includes an outpatient benefit for each day the covered person has surgery in an ambulatory surgical center.

*Your financial security could well depend upon that extra benefit provided by **IndemniCare.***

The great thing about the program is that benefits begin right away—there is no waiting period.

- *Payments may continue for a full 365 days for any one period of confinement.*
- *Indemnity benefits are paid directly to you and you may use them any way you want.*
- *Benefits are paid regardless of any other coverage you may have, including Medicare.*



Who is eligible for Trust IndemniCare Coverage?

As an APA member, you are eligible to apply for *IndemniCare* at very attractive group rates. Your spouse, domestic partner and single dependent children are also eligible for *IndemniCare*.

What benefits does the Plan provide?

IndemniCare is designed to provide a daily cash benefit during periods of hospitalization. It will also provide a daily benefit for outpatient surgery. The policy will pay the elected cash benefit for up to as many as three days of qualified home health care. When an insured is admitted for at least one overnight stay in a hospital under the care of a physician

or psychologist, undergoes outpatient surgery or is subject to a home health care plan, the selected benefit is payable subject to the conditions described in the Policy Exclusions and Limitations section. *Twice* the selected benefit will be paid for each day the insured is in an *Intensive Care Unit*. Half the selected benefit will be paid if the insured is hospitalized for three or more days and then enters an Extended Care Facility within 14 days.

What are my benefit choices?

APA members may choose a daily benefit amount as indicated on the application. Spouses, domestic partners and single dependent children under age 24 may be covered for the same amount as the member.



Definition of Terms

Extended Care Facility (as defined by the Social Security Act) is generally described as a facility, such as a nursing home, which is licensed to provide 24 hour nursing care service in accordance with state and local laws.

Eligible Dependents includes the spouse or domestic partner of the APA member and single dependent children under age 24.

Hospital means a lawfully constituted and operated institution with organized facilities for the care and treatment of sick and injured people on an inpatient basis. It is

staffed at all times with one or more physicians and one or more registered nurses. It is not primarily a place for rest, a place for the aged, a place for the treatment of drug addiction, a place for alcoholics or a nursing or convalescent home.

Physician means a medical practitioner who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures; a licensed dentist; a qualified psychologist practicing in conformity with applicable state laws.



Plan Provisions, Exclusions and Limitations

- For each day of confinement in a hospital, the Daily Benefit is payable.
- For each day of confinement in an intensive care unit, twice the covered person's Daily Benefit is payable.
- For each day of confinement in an extended care facility, skilled nursing facility or rehabilitation facility, one-half the Daily Benefit is payable. Confinement in such a facility must begin within 14 days after a period of hospital confinement lasting at least 3 days, and must be for the same or related cause as the hospital confinement.
- For each day the covered person has surgery in an ambulatory surgical center, the Daily Benefit is payable.
- For each day the covered person is subject to a home health care plan, the Daily Benefit is payable for up to a maximum of 3 days per calendar year.
- In no event will more than one Daily Benefit be payable for any one day.
- Duration of Benefits: For confinement caused by other than Mental Illness, Alcoholism or Drug Addiction - 365 days per disability. For confinement due to Mental Illness, Alcoholism or Drug Addiction - 30 days maximum lifetime benefit.
- Survivor Benefit - The spouse of a deceased APA member may continue coverage.
- A pre-existing condition is a condition resulting from injury or sickness where a covered person incurs any medical charges, takes any medication or is treated for such condition within the 12 month period immediately preceding the effective date of coverage. Benefits will not be payable for any period of hospital confinement as a result of a pre-existing condition. This provision will not apply to any period of hospital confinement caused by a pre-existing condition which begins after any 12 continuous months after the person's effective date of coverage, provided that, throughout the 12 month period the covered person has not received treatment, taken any medication or incurred medical charges due to the pre-existing condition.
- No Daily Benefit is payable for any day of confinement: caused by war or act of war (declared or undeclared); for custodial care; caused by intentionally self-inflicted injuries, while sane or insane; caused by drugs that are voluntarily taken, ingested or injected, unless as prescribed or administered by a physician; caused by active participation in a riot; caused by the covered person committing or attempting to commit an indictable offense.

Termination of Coverage

Your Hospital Indemnity insurance will terminate on the earliest of the following dates:

- The date you cease to be a member of the APA
- The date the master policy held by the Trustees is terminated
- The date you fail to make any agreed payment of premium within the 31 day grace period
- The date you move outside the United States

About Insurability

APA members who are eligible to enroll in any of the programs of Indemnity Insurance described in this brochure must submit evidence of insurability when making application. The insurance will not become effective until the first day of the calendar month following the date that Liberty Mutual determines insurability.



Application for Group IndemniCare Insurance

A Plan Of Hospital Indemnity

Please Print

Member Name _____ APA Membership Number _____

Category of Membership: Full Member _____ Associate Member _____

Home Address _____
Street City State Zip Code

Mailing Address _____
Street City State Zip Code

Home Telephone No.(_____) _____ Business Telephone No.(_____) _____

Male _____ Female _____ Date of Birth _____
Month Day Year

Member: Height _____ Weight _____ Social Security No. _____

First year you became a full/associate member of the American Psychological Association. _____

Have you ever been enrolled in any APA Insurance Programs with Liberty? _____ Yes _____ No

If yes, what type of coverage and is coverage still in effect? _____

Employer _____ Occupation _____

Check The Program You Desire:

- Program A \$75
- Program B \$125
- Program C \$150
- Program D \$175
- Program E \$250
- Program F \$300

Check Individuals To Be Insured:

- Member Only
- Member & Children
- Member, Spouse and/or Domestic Partner
- Family

1. List the dependents you wish to insure. (The only persons you may list are your spouse and your unmarried children under 24 years of age. No one may be insured as a member and a dependent, or as a dependent of two members.)

Last Name	First Name	Initial	Relationship	Date of Birth	Height	Weight
a.						
b.						
c.						
d.						

e.

The following question must be answered:

Do you understand that the policy will not pay benefits for a disease or physical condition caused by pre-existing conditions (conditions which existed prior to being covered by this insurance) for which treatment was rendered or charges were incurred within twelve months before the effective date of insurance? However, do you understand that there is coverage for pre-existing conditions upon the elapse of twelve months free of such treatment (including taking medication) or charges?

I do understand I do not understand

(Signature of Member)

(Date)

(Please complete other side)

detach here

Important: You must answer **Yes** or **No** to each of the following questions. **All boxes must be filled with either “Yes” or “No”** for each person you wish to insure. Do not leave boxes blank as failure to complete all boxes with either a **Yes** or **No** response will cause application to be returned.

1. Have you or your dependents ever been treated for, or had knowledge that you or they were afflicted with: (answer “Yes” or “No”)

	Yourself	Spouse (If Applying)	Children (If Applying)
a. Mental or emotional disorder			
b. Heart, circulatory trouble, high blood pressure or high cholesterol			
c. Diabetes or any Urinary disease			
d. Cancer, tumor, or cyst			
e. Disorder of eyes, ears, nose or throat			
f. Thyroid disorder			
g. Muscular disorder			
h. Treatment for alcohol or drug abuse			
i. Disease of prostate			
j. Back trouble, arthritis, or joint disorders			
k. Convulsions or epilepsy			
l. Disorder of breast or reproductive organ			
m. Liver disorder or kidney disorder			
n. Sexually transmitted disease			
o. Respiratory disorders or lung disease			
p. Ulcers or digestive disorder			
q. AIDS, ARC (AIDS related complex), or ever tested positive for the HTLV-III antibodies			

2. Do you or any of your dependents have any disease, disability or deformity, congenital or otherwise, except as stated above in #2? Yes No

3. For all “Yes” answers in #2 and #3 give details, by individual’s name and by item letter, of any conditions recorded. Give dates, treatment, duration, severity and any recurrence. If space is inadequate, complete and sign statement on a separate sheet.

4. Are you or any of your dependents currently taking any prescription medicine? Yes No **If yes, explain on a separate sheet the type of medication, dosage, how long you have been taking it, and for what condition.**

5. During the past 5 years, have you or any of your dependents, to the best of your knowledge, been treated for or been advised of any condition which may require hospitalization, medical care, or surgical treatment? Yes No **If “Yes”, explain on separate attached sheet.**

6. To the best of your knowledge and belief are either you or your spouse now pregnant? Yes No

7. Have you or any of your dependents ever been rejected, deferred or discharged by the military because of physical or mental conditions? Yes No **If “Yes”, explain on a separate attached sheet.**

8. Have you or any of your dependents ever had any life, disability or health insurance declined, cancelled, not renewed or not approved as applied for? Yes No **If “Yes”, explain on a separate attached sheet.**

9. Declaring that I am a member in good standing or an employee of the American Psychological Association and that all statements and answers, front and back, are complete and true to the best of my knowledge and belief, I hereby apply for coverage as specified on the front of this form, under the APA Plan of Hospital Indemnity Insurance. It is understood and agreed that the foregoing statements and answers are offered to Liberty Life Assurance Company of Boston as an inducement to grant insurance for which application is hereby made. It is further understood that Liberty Life Assurance Company of Boston reserves the right to request additional medical evidence of insurability, if necessary. Agreeing to pay the stipulated premium, I direct any such share of the divisible surplus of the Company as may be credited to the policy shall be paid to the Trustees of the APA Insurance Trust. I understand that I am applying for Hospital Indemnity Insurance.

(Signature of Member)

(Date)

(Signature of Spouse If Applying)

(Date)

**AUTHORIZATION
LIBERTY LIFE ASSURANCE COMPANY OF BOSTON**

I AUTHORIZE any medical practitioner having any information as to the diagnosis, treatment and prognosis of any physical or mental condition of me or my dependents to give any and all such information to Liberty Life Assurance Company of Boston, or to its legal representatives. I UNDERSTAND that the information obtained by use of this Authorization will be used for the purposes of evaluating any application for insurance and adjusting any claim for benefits, if insurance is provided. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE that this Authorization shall be valid for two years and one-half from the date shown below.

(Signature of Member)

(Date)

(Signature of Spouse when Medical Information of Spouse is provided)

(Date)

MAIL TO:
Administrator, APA Group Insurance Plans
Liberty Life Assurance Company of Boston
P.O. Box 1525
Dover, New Hampshire 03821-1525

(Do not send payment with application)

IndemniCare Semiannual Rate Schedule

Premiums are determined by the member's age on the date of issue and the member's age on renewal.

		Member only	Member & Spouse	Member& Child(ren)	Family
Program A - \$75					
Age	0-39	\$24.13	\$55.38	\$41.63	\$72.88
	40-49	\$34.75	\$80.88	\$52.25	\$98.38
	50-59	\$52.38	\$104.13	\$69.88	\$121.63
	60-64	\$73.62	\$146.63	\$91.13	\$164.12
Program B - \$125					
Age	0-39	\$35.88	\$82.75	\$62.13	\$109.00
	40-49	\$51.81	\$121.00	\$78.06	\$147.25
	50-59	\$78.25	\$155.88	\$104.50	\$182.13
	60-64	\$110.12	\$219.62	\$136.37	\$245.87
Program C - \$150					
Age	0-39	\$47.63	\$110.13	\$82.63	\$145.13
	40-49	\$68.88	\$161.13	\$103.88	\$196.13
	50-59	\$104.13	\$207.63	\$139.13	\$242.63
	60-64	\$146.63	\$292.62	\$181.62	\$327.62
Program D - \$175					
Age	0-39	\$59.38	\$137.50	\$103.13	\$181.25
	40-49	\$85.94	\$201.25	\$129.69	\$245.00
	50-59	\$130.00	\$259.38	\$173.75	\$303.13
	60-64	\$183.12	\$365.63	\$226.88	\$409.37
Program E - \$250					
Age	0-39	\$71.25	\$165.00	\$123.75	\$217.50
	40-49	\$103.13	\$241.50	\$155.63	\$294.00
	50-59	\$156.00	\$311.25	\$208.50	\$363.75
	60-64	\$219.75	\$438.75	\$272.25	\$491.25
Program F - \$300					
Age	0-39	\$95.00	\$220.00	\$165.00	\$290.00
	40-49	\$137.50	\$322.00	\$207.50	\$392.00
	50-59	\$208.00	\$415.00	\$278.00	\$485.00
	60-64	\$293.00	\$585.00	\$363.00	\$655.00

General Information

Who may apply for Trust Group Hospital Indemnity Insurance?

You are eligible to apply if you are a member of the American Psychological Association and are under age 65.

Premium

Semiannual premium is due on each October 1 and April 1. In the event that you enter the plan on any date other than on the first day of a premium due date, the premium will be prorated to the next semiannual due date.

When You Have A Claim

Detailed information regarding claims procedure is issued with each new certificate. Promptly report all claims to Liberty Mutual's Home Office.

Administration

This plan is underwritten and administered by Liberty Life Assurance Company of Boston, a member of the Liberty Mutual Group. It is the only Hospital Indemnity program endorsed by the American Psychological Association Insurance Trust and has been in effect for over 20 years. A group Hospital Indemnity policy has been issued to the Trustees of the APA Insurance Trust. Each participating member receives a certificate outlining the benefits to which one is entitled under the policy.

The descriptions in this brochure are necessarily brief and are subject to provisions that can only be expressed exactly in the certificate of insurance which will be sent to you when coverage begins. Have any questions? Call Liberty Mutual at 1-888-287-8494.

Please detach and complete the attached application as soon as possible and mail to:

**Administrator, APA Group Insurance Plans
Liberty Mutual Insurance Company
P.O. Box 1525
Dover, NH 03821-1525**

