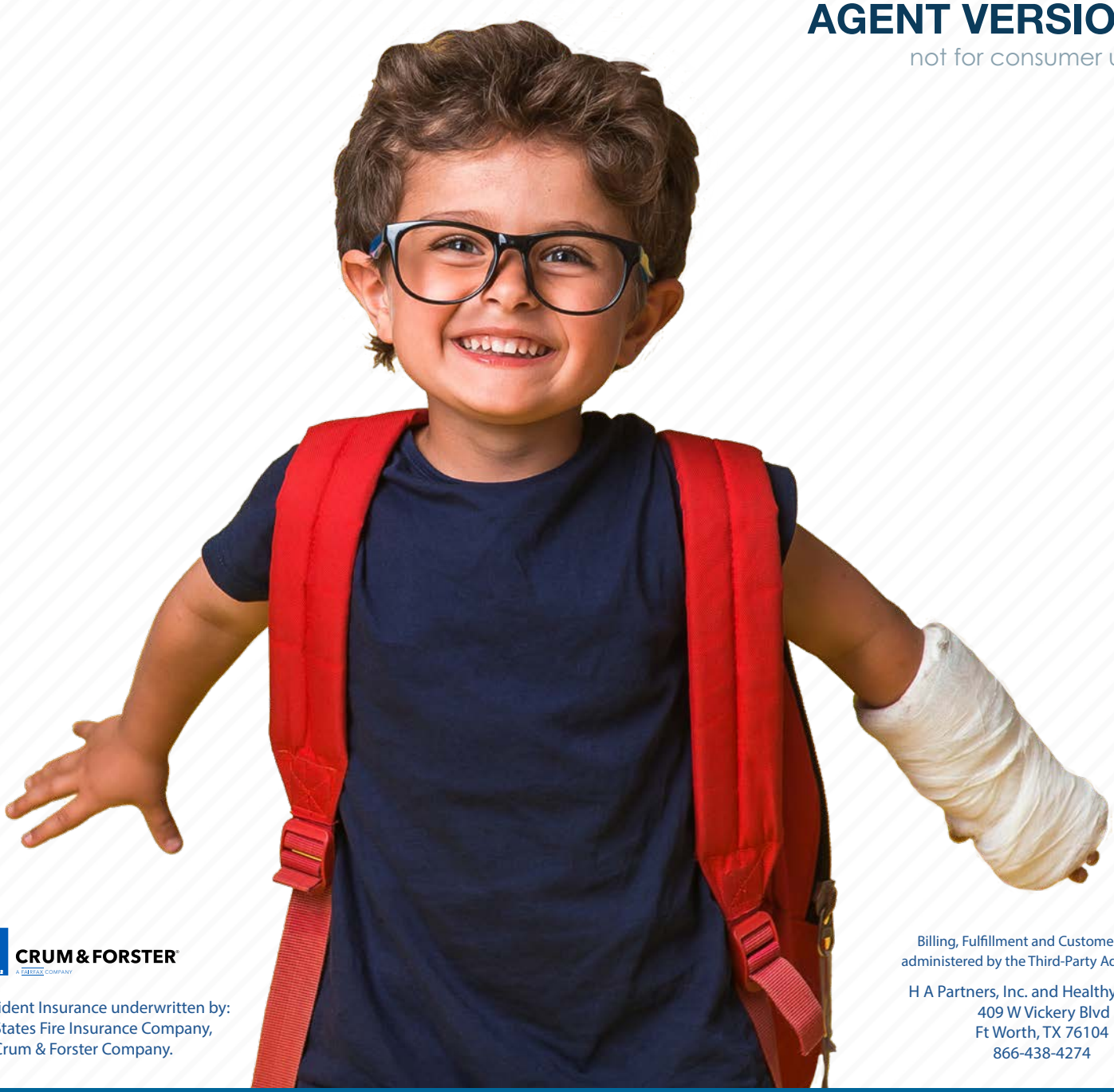
GROUP ACCIDENT INSURANCE
FOR YOUR **SUPPLEMENTAL INSURANCE NEEDS**

AGENT VERSION
not for consumer use



CRUM & FORSTER
A FAIRFAX COMPANY

Group Accident Insurance underwritten by:
United States Fire Insurance Company,
a Crum & Forster Company.

Billing, Fulfillment and Customer Service
administered by the Third-Party Administrator

H A Partners, Inc. and HealthyAmerica
409 W Vickery Blvd
Ft Worth, TX 76104
866-438-4274

UBA

GROUP ACCIDENT INSURANCE
AGENT GUIDE

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AGENT GUIDE

This guide is not for consumer use. This is an in-depth agent guide to get you familiar with the Group Accident Insurance underwritten by United States Fire Insurance Company to the United Business Association. In this guide you will find:

AGENT-SPECIFIC REQUIREMENTS

The following need to be included and compliance practices followed when conducting a sales presentation to market the Group Accident Insurance underewritten by United States Fire Insurance Company.

SALES PROCESS

When enrolling a new member, make sure to read all the information on the enrollment application to the potential member.

This includes:

- Any Acknowledgments
- Disclosures
- Fraud Notices
- Limitations & Exclusions

The applicant must also be told during the enrollment process that they are joining the United Business Association along with the cost of the $10 membership dues that are separate from any Group Accident Insurance premiums and membership plan costs.

The application needs to be reviewed, e-signed and accepted by the applicant. This includes any state specific information, disclosures, and forms, required for that member's state.

OTHER IMPORTANT COMPLIANCE GUIDELINES

- No-Auto Dialers for lead generation.
- Only sell in states you are licensed and appointed with the carrier.
- Keep a recording of the sale (if sale is conducted by phone) from start to finish of the sale. (We will conduct random audits every year of sales recording calls.)
- Give an accurate and true representation of the Group Accident Insurance provided in the plan (including state variations).
- Give the member a copy of the state-specific Certificate **BEFORE** you enroll the potential member so that they can review the group insurance coverage along with all the exclusions, limitations, terms, provisions and conditions.
- Abide by all state and federal laws and regulations with regards to any insurance marketed
- Make sure to explain the cost breakdown to member (Association Dues vs premium) don't lump entire cost or plans together (including additional plans you are selling outside of the UBA plans. Make sure it is clear to the member what they are actually buying and how the cost breaks down for each plan they are purchasing at the same time.) When selling multiple insurance plans, make sure to discuss each type of insurance (i.e. Group Accident, Group Hospital Fixed Indemnity, Critical Illness, Term life, etc. Discuss as separate insurance coverage even though they may be part of the same plan. Make sure to distinguish the coverage separately so that the member understands all of the insurance in their selected plan.)
- Do use the member's correct email address on the enrollment application. This is incredibly important because the email address allows the member to properly review the app, verify, read all state-specific disclaimers, e-sign the enrollment application, receive acceptance email along with link to the member portal which will include the member's ID Card, Certificate and any State Endorsements or Amendatory Riders along with any required State documents, copy of completed and signed application and forms and finally, the United Business Association Member Guide.
- Be certain to enter accurate information which is key to issuance such as a member's residing state, date of birth, the correct address for fulfillment materials, email address for e-signing and member portal access. You are only allowed to sell this group insurance if you are appointed with the carrier. Do not use another person's agent code to complete the app due to non-appointment or not being licensed in a state.

ELIGIBILITY

Currently GAP+ is the only plan that is available for enrollment. All other classes are for explaining coverage to current members already on the membership plans listed in the Schedule of Benefits. While all states might be referenced, new sales may not be available in all states. Specifically, **CA, ID, KS, MO, NJ, NM, PA, & VT are ONLY referenced for explaining coverage to current member and NOT for new sales**.

Looking for coverage for the member, member & spouse or the entire family? Find out the eligibility requirements for enrollment in the Group Accident Insurance underwritten by United States Fire Insurance Company.

ELIGIBILITY FOR INSURANCE*

Persons eligible to be insured under the Policy and the Certificate are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits. This includes anyone who may become eligible while the Policy is in force.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

PRIMARY MEMBER

Ages 18 to under 65 years of age

(Coverage ends for Primary Member at age 79.)

ELIGIBLE DEPENDENTS

Spouse: Under 65 at time of application

(Coverage ends for spouse at age 70)

Dependent Children^: Unmarried and under 26

(Coverage ends for dependent children at age 26 in most states.)

(See the variations for the definitions of Child, Dependent Children, Domestic Partner, Civil Union Partner and Spouse for state-specific variations on pages 27-35.)

CLASS	CLASS ELIGIBILITY
Class 1 GAP AME+ER GAP MAX GAP MAX+	All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP AME or the GAP MAX plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.
Class 2 GAP PLUS 7350	All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP Plus plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.
Class 3 SUPER GAP SUPER GAP PLUS SUPER GAP+	All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the Super Gap or Super GAP Plus plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.
Class 4 GAP PLUS GAP PLUS LEGACY GAP & GAP+	All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the Gap Plus 5000 plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

*The description of Eligibility for Insurance has some state variations based on the various state Certificate of Insurance. **These states have slightly different language than above: AL, AR, AZ, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MI, MO, MS, NC, ND, NE, NJ, OH, OK, PA, RI, SC, TN, VA, VT, WI, WV, & WY.** The variation from the version at the top of the page is highlighted below: Persons eligible to be insured under the Policy and this Certificate are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits **who have completed any applicable Waiting Period.** This includes anyone who may become eligible while the Policy is in force.

This is a very brief description of the Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

HIGHLIGHT[1] OF SCHEDULE OF BENEFITS GROUP ACCIDENT INSURANCE	CLASS 1 GAP AME+ER GAP MAX GAP MAX+	CLASS 2 GAP PLUS 7350	CLASS 3 SUPER GAP SUPER GAP PLUS SUPER GAP+	CLASS 4 GAP PLUS GAP PLUS LEGACY GAP & GAP+
ACCIDENTAL DEATH & DISMEMBERMENT, LOSS OF SIGHT, SPEECH, HEARING BENEFITS				
PRINCIPAL SUM	$5,000	$5,000	$5,000	$2,500
TIME PERIOD FOR LOSS	365 days	365 days	365 days	365 days
ACCIDENT MEDICAL EXPENSE				
ANNUAL MAXIMUM FOR ALL ACCIDENT MEDICAL	$10,000	$7,350	$25,000	$5,000
LOSS PERIOD (FIRST COVERED EXPENSES MUST BE INCURRED WITHIN)	90 days after the Covered Accident	90 days after the Covered Accident	90 days after the Covered Accident	90 days after the Covered Accident
BENEFIT PERIOD	1 year from the date of the Covered Accident or Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary	1 year from the date of the Covered Accident or Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary	1 year from the date of the Covered Accident or Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary	1 year from the date of the Covered Accident or Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary
DEDUCTIBLE	$100.00	$100.00	$100.00	$100.00
TERMS OF PAYMENT	Full Excess **In KS & KY:** It is Primary: Excess over Initial Amount of $100 (not full excess) **In ID, NE & NJ:** It is Primary (not full excess)	Full Excess **In KS & KY:** It is Primary: Excess over Initial Amount of $100 (not full excess) **In ID, NE & NJ:** It is Primary (not full excess)	Full Excess **In KS & KY:** It is Primary: Excess over Initial Amount of $100 (not full excess) **In ID, NE & NJ:** It is Primary (not full excess)	Full Excess **In KS & KY:** It is Primary: Excess over Initial Amount of $100 (not full excess) **In ID, NE & NJ:** It is Primary (not full excess)

Accident Medical Expense Benefits may be available on an allocated or unallocated basis shown, that is to say there may be specific limits or out-of-pocket expenses on certain Covered Expenses (allocated) or all Covered Expenses may be subject to the same maximum limit and out of pocket expenses (unallocated).

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Covered Person, per Covered Accident Basis.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

[1]This is a very brief description of the Group Accident Insurance and Covered Expenses underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

SCOPE OF COVERAGE

Benefits will be provided for those described in the Policy and the Certificate to all Covered Persons who suffer a covered loss which:

1. Is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and results, directly and independently of disease or bodily infirmity, from an Injury which is suffered in an Accident;
2. Occurs while the person is a Covered Person under the Policy and the Certificate; and
3. Is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

STATE VARIATIONS OF SCOPE OF COVERAGE:

CALIFORNIA SCOPE OF COVERAGE: (only for discussing coverage with current members - not new sales)

Benefits will be provided for those described in the Policy and the Certificate to all Covered Persons who suffer a Covered Loss which:

1. Is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and is a proximate result of disease or bodily infirmity, from an Injury which is suffered in an Accident;
2. Occurs while the person is a Covered Person under the Policy and this Certificate; and
3. Is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

GEORGIA SCOPE OF COVERAGE:

Benefits will be provided for those described in the Policy and the Certificate to all Covered Persons who suffer a covered loss which:

1. Is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and results, directly and independently of disease or bodily infirmity, from an Injury which is suffered in an Accident; and
2. Occurs while the person is a Covered Person under the Policy and this Certificate.

VERMONT SCOPE OF COVERAGE: (only for discussing coverage with current members - not new sales)

Benefits will be provided for those described in the Policy and the Certificate to all Covered Persons who suffer a Covered Loss which:

1. Is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and results, directly from an Injury which is suffered in an Accident;
2. Occurs while the person is a Covered Person under the Policy and this Certificate; and
3. Is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

FULL EXCESS MEDICAL EXPENSE

If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, We will pay the Eligible Expenses incurred, subject to any applicable Deductible Amount, Benefit Period, that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury:

1. While the person is insured under the Certificate; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under the Certificate is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

Idaho: Primary Medical Expense (only for discussing coverage with current members - not for new sales)

If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services on the SCHEDULE OF BENEFITS, We will pay the applicable benefit, subject to any applicable Deductible Amount, Benefit Period.

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for treatment of a covered Injury:

1. While the person is insured under this Certificate; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

Such benefits will be paid on a primary basis, regardless of any other coverage the Covered Person may have.

The first Eligible Expense must be incurred within the time frame stated on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Certificate is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

Kansas: Excess Medical Expense (only for discussing coverage with current members - not for new sales.)

The company's liability for benefits payable on account of an expense incurred, for any hospitalization, medical surgical, and other services resulting from covered Injury of the Covered Person, shall be limited to that part of the expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any medical or service contract, self-funded plan, automobile medical payment coverage, or any plan under federal, state or local law (except Medicaid). If one or more of the other policies, plans or service contracts provide benefits on an excess insurance or an excess coverage basis, benefits should be paid first by the company or service plan whose policy or service contract has been in effect for the longer period of time at date of such loss.

The first Eligible Expense must be incurred within the time frame stated on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Policy is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

New Jersey: Primary Medical Expense (only for discussing coverage with current members - not for new sales)

If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services on the SCHEDULE OF BENEFITS, We will pay the applicable benefit, subject to any applicable Deductible Amount, Benefit Period.

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for treatment of a covered Injury:

1. While the person is insured under this Certificate; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

Such benefits will be paid on a primary basis, regardless of any other coverage the Covered Person may have.

The first Eligible Expense must be incurred within the time frame stated on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Certificate is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

Nebraska: Primary Medical Expense
(this is a currently marketed state)

If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services on the SCHEDULE OF BENEFITS,We will pay the applicable benefit, subject to any applicable Deductible Amount, Benefit Period.

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for treatment of a covered Injury:

1. While the person is insured under this Certificate; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

Such benefits will be paid on a primary basis, regardless of any other coverage the Covered Person may have.

The first Eligible Expense must be incurred within the time frame stated on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Certificate is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

This is a very brief description of the Group Accident Insurance and Covered Expenses underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

COORDINATION OF BENEFITS PROVISION:

If a Covered Person is insured for Benefits under this Certificate, and is also covered for these Benefits under one or more other Plans, the benefits payable under this Certificate will be coordinated with the benefits payable under all other Plans. Coordination of Benefits will be used to determine the benefits payable for a Covered Person for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of (1) and (2) below would exceed those Allowable Expenses:

(1) The benefits that would be payable under this Certificate without coordination; and

(2) The benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans.

The benefits that would be payable under this Certificate for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of:

(1) Those required benefits; and

(2) All the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses.

Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Certificate are determined if:

(1) The Benefit Determination Rules would require this Certificate to determine its benefits before that Plan; and

(2) The other Plan has a provision that coordinates its benefits with those of this Certificate and would, based on its rules, determine its benefits after this Certificate.

When Coordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a Covered Person, each benefit that would be payable in the absence of Coordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of this Certificate. We reserve the right to release to or obtain from any other insurance company or other organization or person, any information that, in Our opinion, We or it needs for the purpose of the Coordination of Benefits. When payments that should have been made under this Certificate based on the terms of this provision have been made under any other Plans, We have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under this Certificate. We will be released from all liability under this Certificate to the extent of these payments. When an overpayment has been made by us, at any time, We will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as We may determine.

These states **DO NOT** have this provision in the Certificate of Insurance for that state.

ID, KS, KY, NE, NJ, OH

(ND removes this provision based on ND's Amendatory Rider)

These states **have a variation in the language from above** in the Certificate of Insurance for that state.

CA - VIEW PG 72

MO - VIEW PGS 99-101

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

BENEFIT DETERMINATION RULE:

Benefit Determination Rules - The rules below establish the order in which benefits will be determined:

1. Benefits not as a Dependent: The benefits of a Plan that covers the person for whom claim is made other than as a dependent will be determined before a Plan that covers that person as a dependent.
2. Dependent Benefits under Different Parent Plans: The benefits of a Plan that covers the person for whom claim is made as a dependent of the parent whose birthday falls earlier in the year will be determined before the benefits that covers that person as a dependent under the other parent's Plan.

When both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

Notwithstanding the foregoing, in the case of a dependent child of divorced parents, the following rules will apply:

(a) If there is a court decree that establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan that covers the child as a dependent of the parent so responsible will be determined before any other Plan, otherwise:

(b) The benefits of a Plan that covers the child as a dependent of the parent with custody will be determined before a Plan that covers the child as a dependent of a step-parent or a parent without custody;

(c) The benefits of a Plan that covers the child as a dependent of a step-parent will be determined before a Plan that covers the child as a dependent of the parent without custody.

3. Benefits for Person Longest Covered: When the above rules do not establish the order, the benefits of a Plan that has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time.

In this below sentence:
Notwithstanding the foregoing, in the case of a dependent child of divorced parents, the following rules will apply:

The only variation from above for these states **AL, AR, AZ, CA, DC, DE, FL, GA, IA, IL, IN, LA, MI, MS, NC, ND, NM, OK, PA, RI, SC, TN, VA, VT, WI, WV & WY** is the following change bolded below:

Notwithstanding the foregoing, in the case of a dependent child of divorced **or separated** parents, the following rules will apply:

These states **DO NOT** have this provision in the Certificate of Insurance for that state.	These states **have a variation in the language from above** in the Certificate of Insurance for that state.
ID, KS, KY, NE, NJ, OH	MO - VIEW PGS 99-101

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

RIGHT TO RECEIVE & RELEASE NECESSARY INFORMATION:

For this section to work, We must exchange information with other plans. To do so, We may give to or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any people claiming Benefits under this plan must give to Us the required information.

These states **DO NOT** have this provision in the Certificate of Insurance for that state.	These states **have a variation in the language from above** in the Certificate of Insurance for that state.
ID, KS, KY, NE, NJ, OH	MO - VIEW PGS 99-101

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This is a very brief description of the Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

FACILITY OF PAYMENT:

Another plan may pay a Benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. This will be done at Our discretion. Any amount so paid will be considered a Benefit under this plan. We will not be liable for such payment after it is made.

Whenever used in this provision:

"Plan" means any plan which provides Benefits or services for, or by reason of, Hospital, surgical, medical, or dental care, or treatment through:

1. Group, blanket or franchise insurance coverage;
2. Service plan contracts, group or individual practice or other prepayment plans;
3. Coverage under any labor management trusteed Plans, union welfare plans, employer organization plans, professional organizations, self-funded plans or employee benefit organization plans which provides medical or dental benefits or services; or
4. A government program, or statue, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
5. Medicare (Title XVIII of the Social Security Act); and
6. Any part of a state auto reparation or indemnity act (no-fault insurance) with which the state permits coordination.

Plan does not include coverage under individual or family policies or contracts. Each Plan or part of a Plan that has a right to coordinate benefits will be considered a separate Plan.

"This Plan" means the medical care Benefits provided by the Policy and this Certificate.

"Allowable Expense" means any necessary, Usual, Reasonable and Customary item of expense, incurred while the person (for whom the claim is made) is insured, or is entitled to Benefits after insurance ends, under this Certificate; and at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a calendar year or that part of a calendar year in which the person has been covered under this Certificate.

These states **DO NOT** have this provision in the Certificate of Insurance for that state.

ID, KS, KY, NE, NJ, OH

These states **have a variation in the language from above** in the Certificate of Insurance for that state.

IL - VIEW PG 81
IN - VIEW PG 83
MO - VIEW PGS 99-101
NC - VIEW PG 91
VA - VIEW PG 97

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

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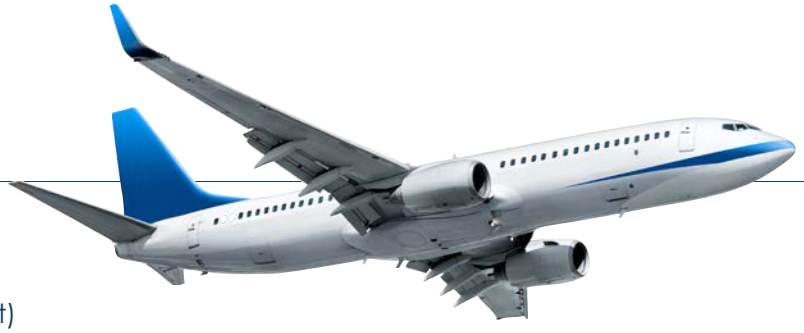
DESCRIPTION OF HAZARDS*

Benefits described in the Policy and Certificate will be paid when a Covered Person suffers a Covered Loss or Injury as a result of a Covered Accident **during one of the Covered Activities listed in the Schedule of Benefits**. Unless otherwise specified, benefits will be paid only once for any one Covered Accident, even if it is covered by more than one Hazard.

*(GA does not have Description of Hazards in its Certificate.)

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)



HAZARD #24: 24 HOUR COVERAGE‡

(except pilots, crew members and Owned Aircraft)

Subject to the Policy and Certificate provisions and Exclusions, benefits described in the Certificate for any Accident which happens to a Covered Person while He is covered by the Certificate will be paid . This includes travel or flight in an Aircraft except as restricted below:

AIRCRAFT RESTRICTIONS

If the Accident happens while a Covered Person is riding in, or getting on or off, an Aircraft, benefits will be paid, but only if:

1. He is riding as a passenger, and not as a pilot or member of the crew; and
2. The Aircraft is not being used for:

   a) Crop Dusting, spraying, or seeding, fire fighting, sky writing; sky diving or hang gliding; pipeline or power line inspection; aerial photography or exploration; racing, endurance tests, stunt or acrobatic flying; or

   b) Any operation which requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because the territory flown over or landed on).

AIRCRAFT NOT COVERED

Benefits will not be paid if the Aircraft is any of the following:

1. Leased Aircraft;
2. Operated or Controlled Aircraft;
3. Owned Aircraft

Unless otherwise state, benefits for a Covered Loss will be paid, only once, even if coverage was provided under more than one Description of Hazards.

‡Hazard #24: 24 Hour Coverage is not in the CA Certificate.

AL, AR, AZ, DC, DE, FL, IA, ID, IL, IN, KS, KY, LA, MI, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, VA, WI, WV, & WY have a variation based on the Certificate. **See below** for the variation in language:

"*during one of the Covered Activities listed in the Schedule of Benefits" that is bolded at the top of the page is not in the below description for the states listed.*

DESCRIPTION OF HAZARDS

We will pay benefits described in the Policy and this Certificate when a Covered Person suffers a Covered Loss or Injury as a result of a Covered Accident. Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if it is covered by more than one Hazard.

IDAHO ADDITIONAL VARIATION: Under Aircraft Restrictions: #2 in ID Certificate is the following: (2) The Aircraft is not being used for any operation which requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

This is a very brief description of the Group Accident Insurance and Covered Expenses underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

DESCRIPTION OF BENEFITS

BENEFITS FOR ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING; OR PARALYSIS†

If, within 1-year from the date of an Accident covered by the Policy and the Certificate, Injury from such Accident, results in Loss listed below, the percentage of the Principal Sum set opposite the loss in the table below will be paid. If the Covered Person sustains more than one such Loss as the result of one Accident, only one amount, the largest to which he is entitled will be paid. This amount will not exceed the Principal Sum which applies for the Covered Person.*

* **In NJ**, this statement is added to the above after the *.
Neither termination of the Policy nor termination of the Covered Person's son's coverage under the Policy shall prejudice the settlement of any claim for loss where the Covered Accident precipitating the Loss occurred on or before the date of termination.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

LOSS	PERCENTAGE OF PRINCIPAL SUM
Loss of Life	100%
Loss of two or more Hands or Feet (Loss of Both Hands in CA, MO & NM) (Loss of Both Feet in CA, MO & NM)	100%
Loss of Speech and Loss of Hearing (both ears) (Loss of Speech and Hearing - both ears in CA, MO & NM)	100%
Loss of Sight (both eyes) (Loss of Entire Sight of Both Eyes in CA & NM)	100%
Loss of one Hand or Foot (Loss of One Hand in CA, MO & NM) (Loss of One Foot in CA, MO & NM) (Loss of One Hand and One Foot in MO)	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Loss of Sight (one eye) (Loss of Entire Sight of One Eye in CA, MO & NM)	50%
Loss of Thumb and Index Finger (same hand)	25%

LOSS OF HAND OR FOOT

means complete Severance through or above the wrist or ankle joint.

LOSS THUMB & INDEX FINGER

means the complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

LOSS OF SIGHT

means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

LOSS OF SPEECH

means total, permanent and irrecoverable loss of audible communication.

LOSS OF HEARING

means total and permanent loss of hearing in both ears which cannot be corrected by any means.

†*The following states **do not have** ; **OR PARALYSIS** in the description of Benefits header: Benefits for Accidental Death, Dismemberment, Loss of Sight, Speech and Hearing; or Paralysis: above in the state-specific Certificate:* **AL, AR, AZ, DE, FL, IA, MI, MS, ND, OK, PA, RI, SC, WI, WV, and WY**

SEVERANCE means the complete separation and dismemberment of the part from the body.

PARALYSIS‡ means loss of use, without Severance, of a limb. This loss must be determined by a Physician to be complete and not reversible.

‡*The following states **do not have** ; the PARALYSIS definition of "Paralysis" above in the state-specific Certificate:* **AL, AR, AZ, CA, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MI, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, VA, VT, WI, WV & WY.**

This is a very brief description of the Group Accident Insurance and Covered Expenses underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

DESCRIPTION OF BENEFITS

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

ACCIDENT MEDICAL EXPENSE BENEFITS

Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident will be paid. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below in the Schedule of Benefits.

Accident Medical Expenses Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 365 days (**30 days instead of 365 days in NJ**) after the date of the Covered Accident.

No benefits will be paid for any expenses that are in excess of Usual and Customary Charges.

Above description is for these states:
AL, AR, AZ, CA, DC, DE, GA, IA, ID, IN, KS, KY, LA, MI, MS, NC, ND, NE, NJ, OH, OK, PA, RI, SC, TN, TX, VA, WI, WV, & WY.

FL, IL, MO, NM & VT replace the description above with the state specific versions below

In Florida:

ACCIDENT MEDICAL EXPENSE BENEFITS

Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident will be paid. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Treatment which is covered on an inpatient basis will also be covered outside the Hospital by health care providers on the same basis as for those covered in the Hospital.

In Illinois:

ACCIDENT MEDICAL EXPENSE BENEFITS

Accident Medical Expense Benefits for Covered Expenses that result directly from a Covered Accident and independently of disease or bodily infirmity will be paid. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below in the Schedule of Benefits.

Accident Medical Expenses Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses that are in excess of Usual and Customary Charges.

In Missouri: (Not available for new sales but to help with explaining coverage for current members only)

(See pages 16-17 for NM's Accident Medical Expense Benefits & Eligible Medical Expenses from a Covered Accident based on the NM Certificate.)

In New Mexico:

(See pages 18-19 for NM's Accident Medical Expense Benefits & Eligible Medical Expenses from a Covered Accident based on the NM Certificate.)

In Vermont: (Not available for new sales but to help with explaining coverage for current members only)

ACCIDENT MEDICAL EXPENSE BENEFITS

Accident Medical Expense Benefits for Covered Expenses that result directly from a Covered Accident. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits. Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

This is a very brief description of the Group Accident Insurance and Covered Expenses underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

ACCIDENT MEDICAL EXPENSE - MO ONLY

THIS IS A DESCRIPTION FROM MO CERTIFICATE AND PAGES 16-17 ONLY APPLY TO MO:

Below are MO Accident Medical Expense Benefit Description for explaining to current customers only. This is not for new sales.

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Eligible Medical Expenses, from a Covered Accident, include:

1. Hospital Admission Expenses: Charges for each hospital admission as shown in the Schedule of Benefits Recurrent Admissions: Separate Hospital admissions due to Injuries from the same Accident will be treated as one Hospital admission, unless separated by at least 3 months.
2. Hospital room and board expenses: charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
3. Intensive Care/Cardiac Care Room and Board - charges for each day of Intensive Care/Cardiac Care Unit confinement, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.
4. Hospital Miscellaneous – services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for the Hospital Miscellaneous benefit. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.
5. Outpatient Pre-Admission Testing Benefit – charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing)
6. Outpatient Hospital Expenses/Emergency Room Treatment - We will pay this benefit up to the Maximum Benefit Amount per emergency shown in the Schedule of Benefits for the Outpatient Emergency Room Treatment benefit. if the Covered Person requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident. This Benefit will cover all services needed during the course of treatment in an Emergency Room. Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.
7. In-Patient Surgical Benefits - charges for:

   (a) A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

   (b) A Physician, for: assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits for an Assistant Surgeon

8. Anesthesia Benefit – Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Anesthesia benefit.
9. Physician's Visits - charges by a Physician for other than pre- or post-operative care:

   (a) For in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

   (b) For office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.

   Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In- Hospital and Office Physician's Visits.
10. Diagnostic X-Ray and Laboratory Benefit - We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires diagnostic x -ray and/or laboratory examinations due to a Covered Loss, up to the Maximum Benefit per Covered Accident indicated in the Schedule of Benefits.
11. Nursing Services – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional Nurse, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Nursing benefit.
12. Physiotherapy - Charges for physiotherapy:

    a. While Hospital confined, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Hospital Inpatient Physiotherapy benefit;

    b. As an outpatient, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

    Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy. Total treatment per Injury will not exceed the Maximum Benefit Amounts for Physiotherapy shown in the Schedule of Benefits.
13. Ambulance - from the place where the Injury occurred to the Hospital, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Ambulance benefit.
14. Medical Equipment Rental/Purchase - charges for a wheelchair or other medical equipment that has therapeutic value for the Covered Person up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Equipment Rental benefit. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs. Rental charges shall not exceed the lesser of the 6 month rental cost or the purchase price of the Medical Equipment.
15. Medical Services and Supplies - Charges for medical services and supplies for:

    (a) Oxygen and its administration;

    (b) Blood and blood transfusions;

    up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Service & Supply benefit.
16. Dental Treatment - Charges for dental treatment including dental x-rays for the repair and treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Dental Treatment benefit.
17. Mental or Nervous Disorders/Psychotherapy - charges for treatment of a disorder that results directly or independently of all other causes from a Covered Accident, while Hospital confined or on an outpatient basis up to the Maximum Benefit Amount shown in the Schedule of Benefits. Benefits are limited to one treatment per day.

    Mental and nervous disorders mean neurosis, psychoneurosis, psychopathic, psychosis, or mental or emotional disease or disorder of any kind.

ACCIDENT MEDICAL EXPENSE - NM ONLY

THIS IS A DESCRIPTION FROM NM CERTIFICATE AND PAGES 18-19 ONLY APPLY TO NM:

Below are NM Accident Medical Expense Benefit Description for explaining to current customers only. This is not for new sales.

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Eligible Medical Expenses, from a Covered Accident, include:

1. Hospital Admission Expenses: Charges for each hospital admission as shown in the Schedule of Benefits Recurrent Admissions: Separate Hospital admissions due to Injuries from the same Accident will be treated as one Hospital admission, unless separated by at least 3 months.

2. Hospital room and board expenses: charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

3. Intensive Care/Cardiac Care Room and Board - charges for each day of Intensive Care/Cardiac Care Unit confinement, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.

4. Hospital Miscellaneous – services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for the Hospital Miscellaneous benefit. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

5. Outpatient Pre-Admission Testing Benefit – charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing)

6. Outpatient Hospital Expenses/Emergency Room Treatment - We will pay this benefit up to the Maximum Benefit Amount per emergency shown in the Schedule of Benefits for the Outpatient Emergency Room Treatment benefit. if the Covered Person requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident. This Benefit will cover all services needed during the course of treatment in an Emergency Room. Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

7. In-Patient Surgical Benefits - charges for:

   (a) A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

   (b) A Physician, for: assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits for an Assistant Surgeon.

ACCIDENT MEDICAL EXPENSE - NM ONLY (Continued)

8. Anesthesia Benefit – Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Anesthesia benefit.
9. Physician's Visits - charges by a Physician for other than pre- or post-operative care:
   (a) For in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

   (b) For office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.

   Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In- Hospital and Office Physician's Visits.
10. Diagnostic X-Ray and Laboratory Benefit - We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires diagnostic x -ray and/or laboratory examinations due to a Covered Loss, up to the Maximum Benefit per Covered Accident indicated in the Schedule of Benefits.
11. Nursing Services – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional Nurse, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Nursing benefit.
12. Physiotherapy - Charges for physiotherapy:
    a. While Hospital confined, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Hospital Inpatient Physiotherapy benefit;

    b. As an outpatient, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

    Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy.

    Total treatment per Injury will not exceed the Maximum Benefit Amounts for Physiotherapy shown in the Schedule of Benefits.
13. Ambulance - from the place where the Injury occurred to the Hospital, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Ambulance benefit.
14. Medical Equipment Rental/Purchase - charges for a wheelchair or other medical equipment that has therapeutic value for the Covered Person up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Equipment Rental benefit. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs. Rental charges shall not exceed the lesser of the 6 month rental cost or the purchase price of the Medical Equipment.
15. Medical Services and Supplies - Charges for medical services and supplies for:
    a. Oxygen and its administration;

    b. Blood and blood transfusions;

    up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Service & Supply benefit.
16. Dental Treatment - Charges for dental treatment including dental x-rays for the repair and treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Dental Treatment benefit.
17. Mental or Nervous Disorders/Psychotherapy - charges for treatment of a disorder that results directly or independently of all other causes from a Covered Accident, while Hospital confined or on an outpatient basis up to the Maximum Benefit Amount shown in the Schedule of Benefits. Benefits are limited to one treatment per day.

    Mental and nervous disorders mean neurosis, psychoneurosis, psychopathic, psychosis, or mental or emotional disease or disorder of any kind.

The definitions below are for all Group Accident Insurance states underwritten by United State Fire Insurance Company to United Business Association (**based on the TX Certificate of Insurance**). Some states may have variations or added definitions. Those variations and added definitions will be located between pages 27-35. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.
(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP ACCIDENT INSURANCE	
Accident	"Accident" means a sudden, unforeseeable external event which: (1) Causes Injury to one or more Covered Persons; and (2) Occurs while coverage is in effect for the Covered Person.
Aircraft	"Aircraft" means a vehicle which: (1) Has a valid certificate of airworthiness; and (2) Is being flown by a pilot with a valid license appropriate to the aircraft.
Benefit Period	"Benefit Period" means the period of time from the date of the Accident causing the Injury for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.
Certificate holder	Certificate Holder means a person to whom this insurance certificate has been issued evidencing coverage under the Policy and this Certificate.
Child	Child means the Covered Person's natural Child, adopted Child (or Child for whom You are a party to a suit in which You seek to adopt the Child), grandchild, foster Child, stepchild, or other Child for whom the Covered Person has legal guardianship (proof will be required). A child also includes a child for whom You must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in Texas. A child of Your child (grandchild) must be unmarried, under 25 years of age, and dependent on you for federal income tax purposes at the time application for coverage for the child is made. However, existing coverage for a grandchild may not be terminated solely because the grandchild is no longer a dependent for federal income tax purposes. **AL, AZ, DC, CA, DE, IA, KS, KY, LA, MI, MO, MS, NE, NJ, NM, ND, OH, OK, PA, RI, SC, TN, WV, WI and WY** all **replace** the above definition with the following definition: Child means the Covered Person's natural Child, adopted Child (or Child placed in the Covered Person's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Covered Person has legal guardianship (proof will be required). A Child must reside with the Covered Person in a parent-Child relationship and be eligible to be claimed as an exemption on the Covered Person's federal income tax return. NOTE: In the event the Covered Person shares physical custody of the Child with another parent, the requirement that the Child reside with the Covered Person will be waived. **Arkansas** has a variation based on the AR Certificate. **See page 27** for variation of definition. **Florida** has a variation based on the FL Certificate. **See page 29** for variation of definition. **Georgia** has a variation based on the GA Certificate. **See page 30** for variation of definition. **Illinois** has a variation based on the IL Certificate. **See page 30** for variation of definition. **Indiana** has a variation based on the IN Certificate. **See page 31** for variation of definition. **North Carolina** has a variation based on the NC Certificate. **See page 33** for variation of definition **Vermont** has a variation based on the VT Certificate. **See page 34** for variation of definition
Company	"Company" means United States Fire Insurance Company. Also hereinafter referred to as We, Us and Our.
Covered Accident	Covered Accident means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss for which benefits are payable.
Covered Loss or Covered Losses	Covered Loss or Covered Losses means an accidental death, dismemberment or other Injury covered under the Policy and this Certificate and indicated on the Schedule of Benefits.
Covered Person	"Covered Person" means an Insured Person and Dependent eligible for coverage as identified in the Enrollment/Application who is a U.S. citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States,for whom proper premium payment has been made when due, and who is therefore insured under the Policy and this Certificate. **California** has a variation based on the CA Certificate. **See page 27** for variation of definition.
Deductible	"Deductible" means the dollar amount of Eligible Expenses which must be incurred and paid by the Covered Person before benefits are payable under the Policy and this Certificate. It applies separately to each Covered Person. **California & Idaho** do not have the definition of Deductible in the CA or ID Certificates.

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

The definitions below are for all Group Accident Insurance states underwritten by United State Fire Insurance Company to United Business Association (**based on the TX Certificate of Insurance**). Some states may have variations or added definitions. Those variations and added definitions will be located between pages 27-35. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.
(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP ACCIDENT INSURANCE	
Dependent	"Dependent" means a Covered Person's: 1) lawful spouse, if not legally divorced, or Domestic Partner. 2) unmarried Children under age 26. The age limitations will not apply to a Covered Person's unmarried Child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation. **AL, AZ, CA, DC, DE, FL, IA, IL, IN, KS, KY, MI, MS, NE, NJ, NM, ND, OH, OK, PA, RI, SC, TN, WV, WI & WY** all **replace** the above definition with the following definition: Dependent means a Covered Person's: 1. lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner. 2. unmarried Children under age 26. The age limitations will not apply to a Covered Person's unmarried Child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation. **Arkansas** has a variation based on the AR Certificate. **See page 27** for variation of definition. **Georgia** has a variation based on the GA Certificate. **See page 30** for variation of definition. **Louisiana** has a variation based on the LA Certificate. **See page 31** for variation of definition. **Missouri** has a variation based on the MO Certificate. **See page 31** for variation of definition. **North Carolina** has a variation based on the NC Certificate. **See page 33** for variation of definition. **Vermont** has a variation based on the VT Certificate. **See page 34** for variation of definition. **Virginia** has a variation based on the VA Certificate. **See page 35** for variation of definition.
Domestic Partner	"Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Covered Person and shared financial assets/obligations with the Covered Person. Both the Covered Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership. **California** has a variation based on the CA Certificate. **See page 27** for variation of definition. **Florida** has a variation based on the FL Certificate. **See page 29** for variation of definition. **Idaho** does not have the Domestic Partner definition in the ID Certificate. **New Jersey** has a variation based on the NJ Certificate. **See page 32** for variation of definition.
Eligible Expenses	"Eligible Expenses" means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while the Policy and this Certificate is in force.
Emergency Care	"Emergency Care" means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition or Injury is of such a nature that failure to get immediate medical care could result in: 1) Placing the patient's health in serious jeopardy; 2) Serious impairment of bodily functions; 3) Serious dysfunction of any bodily organ or part; 4) Serious disfigurement; or 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus. **This definition is NOT in any of these State Certificates: AL, AR, AZ, CA, DC, DE, FL, GA, IA, IL, IN, KS, KY, LA, MI, MO, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, WV, WI and WY.**
He, His, Him, She, Her & Hers	"He", "His" and "Him" includes "she", "her" and "hers."

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

The definitions below are for all Group Accident Insurance states underwritten by United State Fire Insurance Company to United Business Association (**based on the TX Certificate of Insurance**). Some states may have variations or added definitions. Those variations and added definitions will be located between pages 27-35. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP ACCIDENT INSURANCE	
Health Care Plan	"Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under: 1. Group or blanket insurance, whether on an insured or self-funded basis; 2. Hospital or medical service organizations on a group basis; 3. Health Maintenance Organizations on a group basis. 4. Group labor management plans; 5. Employee benefit organization plan; 6. Professional association plans on a group basis; or 7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or 8. Automobile no-fault coverage (unless prohibited by law). **California** has a variation based on the CA Certificate. **See page 27** for variation of definition. **Missouri** has a variation based on the MO Certificate. **See page 31** for variation of definition. **North Carolina** has a variation based on the NC Certificate. **See page 33** for variation of definition. **Virginia** has a variation based on the VA Certificate. **See page 35** for variation of definition.
Hospital	"Hospital" means an institution which: 1. Is operated pursuant to law; 2. Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis; 3. Is under the supervision of a staff of Physicians; 4. Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.); 5. Has medical, diagnostic and treatment facilities, with major surgical facilities; (a) On its premises; or (b) Available to it on a prearranged basis; and 6. Charges for its services. "Hospital" does not include: 1. A clinic or facility for: (a) Convalescent, custodial, educational or nursing care; (b) The aged, drug addicts or alcoholics; or (c) Rehabilitation; or 2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless: (a) The services are rendered on an emergency basis; and (b) A legal liability exists for the charges made to the individual for the services given in the absence of insurance. **Florida** has a variation based on the FL Certificate. **See page 29** for variation of definition. **Missouri** has a variation based on the MO Certificate. **See page 32** for variation of definition. **New Jersey** has a variation based on the NJ Certificate. **See page 32** for variation of definition. **North Carolina** has a variation based on the NC Certificate. **See page 33** for variation of definition.
Hospital Stay	"Hospital Stay" means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

The definitions below are for all Group Accident Insurance states underwritten by United State Fire Insurance Company to United Business Association (**based on the TX Certificate of Insurance**). Some states may have variations or added definitions. Those variations and added definitions will be located between pages 27-35. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.
(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP ACCIDENT INSURANCE	
Immediate Family	"Immediate Family" means a Covered Persons spouse, domestic partner, parent, Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws. **AL, AR, AZ, CA, DC, DE, FL, GA, IA, IL, IN, KS, KY, LA, MI, MO, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, WI, WV, & WY** all **replace** the above definition with the following definition: Immediate Family means a Covered Persons spouse, domestic partner, civil union partner, parent, Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws. **Idaho** has a variation based on the ID Certificate. **See page 30** for variation of definition. **Virginia** are the same as TX definition at the top of the Immediate Family definition Section.
Injury	"Injury" means bodily injury caused by an Accident. It must result, directly and independently of all other causes, in a Covered Loss. **AL, AR, AZ, DC, DE, FL, GA, IA, IL, IN, KS, KY, LA, MI, MO, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, VA, WI, WV, & WY replaces** the above definition with the following definition: Injury means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury. **California** has a variation based on the CA Certificate. **See page 27** for variation of definition. **Vermont** has a variation based on the VT Certificate. **See page 34** for variation of definition.
Insured Person	Insured Person means an member of the Policyholder who is eligible and insured for coverage under the Policy and this Certificate and who is not a dependent.
Leased Aircraft	"Leased Aircraft" means an aircraft for which the Policyholder or any of its subsidiaries or affiliates has a written lease under whose terms, the aircraft: 1. Can be used at the Policyholder's or any of its subsidiaries' or affiliates' discretion; 2. Can be used by the Policyholder or any of its subsidiaries or affiliates for 2 or more trips or for more than 10 consecutive days; and 3. Cannot be altered or sold by the Policyholder or any of its subsidiaries or affiliates, without the consent of the leaser or owner. "Leased Aircraft" does not include any Owned Aircraft.
Medically Necessary	"MEDICALLY NECESSARY" means a condition requiring Emergency Care. **AL, AR, AZ, DE, FL, GA, IA, KS, KY, LA, MI, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, VA, WI, & WV** all **replace** the above definition with the following definition: "Medically Necessary" or "Medical Necessity" means a treatment, service or supply that is: 1. required to treat an Injury; 2. prescribed or ordered by a Physician or furnished by a Hospital; 3. performed in the least costly setting required by the condition; 4. consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary. The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy or this Certificate. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense. **California** has a variation based on the CA Certificate. **See page 28** for variation of definition. **DC** only variation is DC doesn't refer to Certificate, only Group Policy. **See page 28** for variation. **Illinois** has a variation based on the IL Certificate. **See page 30** for variation of definition. **Indiana** has a variation based on the IN Certificate. **See page 31** for variation of definition. **Wyoming** has a variation based on the WY Certificate. **See page 35** for variation of definition.

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

The definitions below are for all Group Accident Insurance states underwritten by United State Fire Insurance Company to United Business Association (**based on the TX Certificate of Insurance**). Some states may have variations or added definitions. Those variations and added definitions will be located between pages 27-35. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.
(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP ACCIDENT INSURANCE	
Nurse	"Nurse" means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).
Occurrence	"Occurrence" means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur. **Illinois** has a variation based on the IL Certificate. **See page 30** for variation of definition.
Operated or Controlled Aircraft	"Operated or Controlled Aircraft" means an aircraft which: 1. Has been leased, rented or borrowed by the Policyholder for at least 10 consecutive days, or more than 15 days in any one year; 2. Can be used at the Policyholder's discretion; and 3. Cannot be altered or sold by the Policyholder without the consent of the owner or leaser. "Operated or Controlled Aircraft" does not include any Owned Aircraft.
Owned Aircraft	"Owned Aircraft" means aircraft to which the Policyholder or any of its subsidiaries or affiliates holds legal or equitable title.
Physician	"PHYSICIAN" means a person who is a qualified practitioner of the healing arts, including an acupuncturist, advanced practice nurse, audiologist, chemical dependency counselor, chiropractor, dentist, dietitian, hearing instrument fitter and dispenser, licensed clinical social worker, licensed professional counselor, marriage and family therapist, occupational therapist, optometrist, physical therapist, physician, physician assistant, podiatrist, psychological associate, psychologist, speech-language pathologist and surgical assistant. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person's spouse, son, daughter, father, mother, brother or sister or other relative, except with regard to a dentist. **AL, AR, AZ, DC, DE, FL, GA, IA, IL, IN, KS, KY, MI, MO, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, VA, WI, WV & WY** all **replace** the above definition with the following definition: Physician means a person who is a qualified practitioner of medicine. As such, He or She must be acting within the scope of his/her license under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person's spouse, son, daughter, father, mother, brother or sister or other relative. **California** has a variation based on the CA Certificate. **See page 28** for variation of definition. **Louisiana** has a variation based on the LA Certificate. **See page 31** for variation of definition.
Policyholder	"Policyholder" means the entity shown as the Policyholder in the Schedule of Benefits.
Prescription Drugs	"Prescription Drugs" means drugs which may only be dispensed by written prescription under Federal law, and reapproved for general use by the Food and Drug Administration.
Rehabilitation Facility	"Rehabilitation Facility" means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. The facility may be either of the following: (a) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or (b) A free standing facility

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

The definitions below are for all Group Accident Insurance states underwritten by United State Fire Insurance Company to United Business Association (**based on the TX Certificate of Insurance**). Some states may have variations or added definitions. Those variations and added definitions will be located between pages 27-35. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.
(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP ACCIDENT INSURANCE	
Sound Natural Teeth	"Sound Natural Teeth" means natural teeth, the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective. **California** has a variation based on the CA Certificate. **See page 28** for variation of definition.
Spouse	"Spouse" means lawful spouse, if not legally divorced, or Domestic Partner. **AL, AR, AZ, DE, FL, IA, IL, IN, KS, KY, LA, MI, MO, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, WI, WV & WY** all **replace** the above definition with the following definition: Spouse means lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Partner. **California** has a variation based on the CA Certificate. **See page 28** for variation of definition. **DC** has a variation based on the DC Certificate. **See page 28** for variation of definition. **Georgia** has a variation based on the GA Certificate. **See page 30** for variation of definition. **Idaho** has a variation based on the ID Certificate. **See page 30** for variation of definition. **Virginia** has a variation based on the VA Certificate. **See page 35** for variation of definition.
Usual, Reasonable, and Customary	"Usual, Reasonable and Customary means: 1. With respect to fees or charges, fees for medical services or supplies which are; (a) Usually charged by the provider for the service or supply given; and (b) The average charged for the service or supply in the locality in which the service or supply is received; or 2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition. **California** has a variation based on the CA Certificate. **See page 28** for variation of definition. **Florida** has a variation based on the FL Certificate. **See page 29** for variation of definition.
We, Our, Us	We, Our, Us means United States Fire Insurance Company underwriting this insurance.
You, Your Yours	You, Your, Yours, He or She means the Covered Person who meets the eligibility requirements of the Policy and the Certificate and whose insurance under the Policy and this Certificate is in force.
Civil Union Partner	**This definition is NOT in the TX Certificate of Insurance**. See below for states that have this additional definition. **AL, AZ, AR, CA, DC, DE, FL, GA, IA, IL, IN, KS, KY, LA, MI, MO, MS, NE, NM, ND, OH, OK, PA, RI, SC, TN, WV, WI & WY** all **replace** the above definition with the following definition: Civil Union Partner: The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded to spouses. Throughout the Policy and this Certificate, a party to a civil union shall be included in any definition or use of the terms such as spouse, family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used. **Idaho** also does not have Civil Union Definition in the ID Certificate. **New Jersey** has a variation based on the NJ Certificate. **See page 32** for variation of definition.

Additional Definitions that are specific to State Certificates and not listed between pages 20-25:

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

STATE VARIATIONS AND ADDITIONS

DEFINITION STATE VARIATIONS

In this section of the agent guide (pages 27-35), all of the state variations that are different from the definitions listed between pages 20-25 are detailed. The descriptions are done alphabetically. You will find all variations or additions for that state within each state section. Some states may carry over to multiple pages depending on the amount of variations or additions.

Make sure that BEFORE you discuss the right coverage, terms, definitions, limitations and exclusions with a client that you are reviewing the state-specific version so that you are giving the member the correct information for their home state.

QUICK STATE PAGES REFERENCE

*These states are no longer being marketed. The definitions for these states are **ONLY** for explanation purposes for current members and not for any NEW sales.

DEFINITION TERM[1]	DEFINITION MEANING[1]
ARKANSAS	
Child	"Child" means the Covered Person's natural Child, adopted Child (or Child placed in the Covered Person's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Covered Person has legal guardianship (proof will be required). A Child must reside with the Covered Person in a parent-Child relationship and be eligible to be claimed as an exemption on the Covered Person's federal income tax return. NOTE: In the event the Covered Person shares physical custody of the Child with another parent, the requirement that the Child reside with the Covered Person will be waived
Dependent	"Dependent" means a Covered Person's: 1. lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner. 2. unmarried Children under age 26. The age limitations will not apply to a Covered Person's unmarried Child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation. **The definition of DEPENDENT is amended based on the Amendatory Rider as follows in AR:** The 31 day requirement for due proof of a Child's incapacity is deleted. We will require notice of the Child's incapacity and dependency. In no event, however, will this requirement preclude eligible Dependents regardless of age. If dependency or incapacity is removed or terminated the Covered Person must notify Us.
CALIFORNIA	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN CA**.
Covered Person	"Covered Person" means an Insured Person and Dependent eligible for coverage as identified in the Enrollment/Application who is a permanent resident of the United States, for whom proper premium payment has been made when due, and who is therefore insured under the Policy and this Certificate.
Domestic Partner	"Domestic Partner" means the Insured's domestic partner under a domestic partnership that is currently registered with the California Secretary of State (or other governmental body pursuant to comparable applicable law of another state).
Health Care Plan	"Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under: 1. Group or blanket insurance, whether on an insured or self-funded basis; 2. Hospital or medical service organizations on a group basis; 3. Health Maintenance Organizations on a group basis. 4. Group labor management plans; 5. Employee benefit organization plan; 6. Professional association plans on a group basis; or 7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.
Injury	"Injury" means bodily harm of which an Accident is the proximate cause. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

DEFINITION TERM[1]	DEFINITION MEANING[1]
CALIFORNIA	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN CA**.
Medically Necessary or Medical Necessity	"Medically Necessary" or "Medical Necessity" services and procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are: 1. in accordance with generally accepted standards of medical practice; and 2. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and 3. not primarily for the convenience of the Covered Person, Physician or other health care provider; and 4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's illness, Injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.
Physician	"Physician" means a person who is a Physician of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that is required by law to be licensed and is acting within the scope of his/her license under the laws in the state in which he/she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include an Insured, an Insured's Spouse, Domestic Partner, son, daughter, father, mother, brother or sister or other relative;
Spouse	"Spouse" means a Domestic Partner or person recognized by law as being married to the Insured, if not legally separated or divorced, or Civil Partner.
Usual, Reasonable and Customary	"Usual, Reasonable and Customary" means 1) With respect to fees or charges, fees for medical services or supplies which are; a) Usually charged for the service or supply given: and b) The average charged for the service or supply given: and b) the average charged for the service or supply within California; or 2) With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.
Sound Natural Teeth	"Sound Natural Teeth" means natural teeth, the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious or abscessed.
DISTRICT OF COLUMBIA (DC)	
Medically Necessary or Medical Necessity	"Medically Necessary" or "Medical Necessity" means a treatment, service or supply that is: 1. required to treat an Injury; 2. prescribed or ordered by a Physician or furnished by a Hospital; 3. performed in the least costly setting required by the condition; 4. consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary. The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.
Spouse	"Spouse" means a person of the same or opposite sex who is legally married to the insured under the laws of the state or jurisdiction in which the marriage took place. Spouse includes Domestic Partner or Civil Union Partner.

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

DEFINITION TERM[1]	DEFINITION MEANING[1]
FLORIDA	
Child	"Child" means the Covered Person's natural Child, adopted Child (or Child placed in the Covered Person's home for purposes of adoption pending finalization of adoption procedures), foster Child, stepchild, custodial child or other Child for whom the Covered Person has legal guardianship (proof will be required) and children for whom coverage has been court-ordered. Dependent children (other than children for whom coverage has been court-ordered), must: (a) have their principal residence with the Covered Person (except stepchildren and foster children); and (b) chiefly rely on the Covered Person for support and maintenance.
Domestic Partner	"Domestic Partner" means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Covered Person and shared financial assets/obligations with the Covered Person. Both the Covered Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner.
Hospital	"Hospital" means an institution which: 1. Is operated pursuant to law; 2. Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis; 3. Is under the supervision of a staff of Physicians; 4. Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.); 5. Has medical, diagnostic and treatment facilities, with major surgical facilities; (a) On its premises; or (b) Available to it on a prearranged basis; and 6. Charges for its services. Hospital also includes a licensed emergency treatment center. The center must have permanent facilities and: 1. a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) present at all times; 2. an M.D. specialist representing each of the major specialties available within minutes; 3. ancillary services, including laboratory and X-ray, staffed at all times; and 4. a pharmacy staffed, or on call, at all times. "Hospital" does not include: 1. A clinic or facility for: (a) Convalescent, custodial, educational or nursing care; (b) The aged, drug addicts or alcoholics; or (c) Rehabilitation; or 2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless: (a) The services are rendered on an emergency basis; and (b) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.
Usual, Reasonable and Customary	"Usual, Reasonable and Customary" means the fee regularly charged and received for a given service by a health care provider when furnishing customary treatment for a similar condition or Injury as represented by the 80th percentile of the MDR database. We shall provide to a Covered Person, upon his written request, an estimate of the amount We will pay for a particular procedure or service. However, We will not be bound by such good faith estimate.
Example of How Claims are Paid using "Usual and Customary Charges"	Example of How Claims are Paid Using "Usual and Customary Charges": A Covered Person submits a $310 claim to Us for covered medical expenses incurred for treatment of an Injury sustained in a covered Accident. We then input the treatment codes supplied by the provider, along with the provider's zip code, into the MDR database and find that the 80th percentile is determined to be $300. We then process the claim using $300 as the "Usual and Customary Charge".

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

DEFINITION TERM[1]	DEFINITION MEANING[1]
GEORGIA	
Child	"Child" means the Covered Person's natural Child, adopted Child (or Child placed in the Covered Person's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Covered Person has legal guardianship (proof will be required).
Dependent	"Dependent" means a Covered Person's: 1. lawful spouse, if not legally divorced, or Domestic Partner or Civil Union Partner. 2. unmarried Children under age 26. The age limitations will not apply to a Covered Person's unmarried Child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.
Spouse	"Spouse" means lawful spouse, if not legally divorced, or Domestic Partner or Civil Partner.
ILLINOIS	
Child	"Child" means the Covered Person's natural Child, adopted Child (or Child placed in the Covered Person's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Covered Person has legal guardianship (proof will be required). A Child who is in the custody of the Covered Person, pursuant to an interim court order of adoption or placement of adoption, whichever comes first, vesting temporary care of the Child in the Covered Person, is an adopted Child, regardless of whether a final order granting adoption is ultimately issued.
Intoxicated	"Intoxicated" means that which is defined and determined by the laws of the state where the loss or cause of the loss was incurred.
Medically Necessary or Medical Necessity	"Medically Necessary" or "Medical Necessity" means a treatment, service or supply that is: 1. required to treat an Injury; 2. prescribed or ordered by a Physician or furnished by a Hospital; 3. performed in the least costly setting required by the condition; 4. consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary. The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy or this Certificate. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Covered Expense.
Occurrence	"Occurrence" means all losses or damages that are attributable directly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.
IDAHO	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN ID**.
Immediate Family	"Immediate Family" means a Covered Persons spouse, parent, Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws.
Placed or Placement	"Placed or Placement" means physical placement in the Covered Person's care for adoptive purposes, or in those circumstances in which such physical placement is prevented due to the medical needs of the Child requiring placement in a medical facility, it shall mean when the Covered Person signs an agreement for adoption of such Child and he signs an agreement assuming financial responsibility for such Child.
Spouse	"Spouse" means the legally married opposite sex spouse of the Covered Person.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
INDIANA	
Child	"Child" means the Covered Person's natural Child, adopted Child (or Child placed in the Covered Person's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Covered Person has legal guardianship (proof will be required).
Medically Necessary or Medical Necessity	"Medically Necessary" or "Medical Necessity" means a treatment, service or supply that is: 1. required to treat an Injury; 2. prescribed or ordered by a Physician or furnished by a Hospital; 3. performed in the least costly setting required by the condition; 4. consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary. The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy or this Certificate. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, consider the cost of the alternative to be the Covered Expense.
LOUISIANA	
Dependent	"Dependent" means a Covered Person's: 1. lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner. 2. unmarried Children or grandchildren under age 26. The Covered Person's grandchild must be in the legal custody of and residing with the Covered Person. The age limitations will not apply to a Covered Person's unmarried Child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.
Physician	"Physician" means a person who is a qualified practitioner of the healing arts, including a chiropractor, optometrist and a dental practitioner. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person's spouse, son, daughter, father, mother, brother or sister or other relative. Physician also includes, but is not limited to, a duly licensed: podiatrist, optometrist, psychologist, and clinical social worker. We shall not deny coverage of perioperative services rendered by a registered nurse first assistant if We cover the same such first assistant perioperative services when they are rendered by an advanced practice nurse, a physician assistant, or a physician other than the operating surgeon.
MISSOURI	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN MO**.
Dependent	"Dependent" means a Covered Person's: 1. lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner. 2. unmarried Children under age 26; and 3. A resident of Missouri; and 4. Not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Medicare. The age limitations will not apply to a Covered Person's unmarried Child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.
Health Care Plan	"Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under: 1. Group or blanket insurance, whether on an insured or self-funded basis; 2. Hospital or medical service organizations on a group basis; 3. Health Maintenance Organizations on a group basis. 4. Group labor management plans; 5. Employee benefit organization plan; 6. Professional association plans on a group basis; or 7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended

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DEFINITION TERM[1]	DEFINITION MEANING[1]
MISSOURI	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN MO**.
Hospital	"Hospital" means an institution which: 1. Is operated pursuant to law; 2. Is an organized facility engaged in providing medical care and treatment to sick and injured persons on a resident or inpatient basis; 3. Includes facilities for diagnosis and surgery under the supervision of a staff of one (1) or more licensed Physicians; and 4. Provides 24-hour nursing service by or under the supervision of a registered nurse, (R.N.) on duty or on call. "Hospital" does not include convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though the facilities are operated as a separate institution by a hospital.
NEW JERSEY	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN NJ**
Civil Union Partner	"Civil Union Partner": The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded to spouses. Throughout the Policy, a party to a civil union shall be included in any definition or use of the terms such as spouse, family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes civil union relationships entered outside of New Jersey that provide substantially all of the rights and benefits of marriage and are valid under the laws of the jurisdiction in which the civil union relationship was entered This also includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used.
Domestic Partner	"Domestic Partner" means a same sex partner meet the following requirements: 1. Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following: (a) a joint deed, mortgage agreement or lease; (b) a joint bank account; (c) designation of one of the persons as a primary beneficiary in the other person's will; (d) designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or (e) joint ownership of a motor vehicle; 2. Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership; 3. Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership; 4. Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity; 5. Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older and not of the same sex may establish a domestic partnership; 6. Both persons have chosen to share each other's lives in a committed relationship of mutual caring; 7. Both persons are at least 18 years of age; 8. Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died). The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.
Hospital	"Hospital" means an institution which: 1. Is operated pursuant to law; 2. Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis; 3. Is under the supervision of a staff of Physicians; 4. Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.); 5. Has medical, diagnostic and treatment facilities, with major surgical facilities; (a) On its premises; or (b) Available to it on a prearranged basis. "Hospital" does not include: 1. A clinic or facility for: (a) Convalescent, custodial, educational or nursing care; (b) The aged, drug addicts or alcoholics; or (c) Rehabilitation; or 2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless: (a) The services are rendered on an emergency basis; and (b) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
NORTH CAROLINA	
Child	"Child" means the Covered Person's natural Child, adopted Child (or Child placed in the Covered Person's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Covered Person has legal guardianship (proof will be required).
Complications of Pregnancy	"COMPLICATIONS of PREGNANCY" means a condition which: • When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy. • When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible; Complications of Pregnancy will not include: • False Labor; • Occasional spotting; • Physician prescribed rest during the period of pregnancy; • Morning Sickness; • Preeclampsia; and • Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy. Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.
Dependent	"Dependent" means a Covered Person's: 1. lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner. 2. unmarried Children under age 26. The age limitations will not apply to a Covered Person's unmarried Child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required not more often than once a year following the age limitation.
Health Care Plan	"Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under: 1. Group or blanket insurance, whether on an insured or self-funded basis; 2. Hospital or medical service organizations on a group basis; 3. Health Maintenance Organizations on a group basis. 4. Group labor management plans; 5. Employee benefit organization plan; 6. Professional association plans on a group basis; or 7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended
Hospital	"Hospital" means an institution which: 1. Is operated pursuant to law; 2. Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis; 3. Is under the supervision of a staff of Physicians; 4. Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.); 5. Has medical, diagnostic and treatment facilities, with major surgical facilities; (a) On its premises; or (b) Available to it on a prearranged basis; and 6. Charges for its services. Hospital also includes a duly licensed State tax-supported institution or specialty facility even if it does not have an operating room and related equipment for the performance of surgery. The term "State tax-supported institutions" shall include community mental health centers and other health clinics which are certified as Medicaid providers. "Hospital" does not include: 1. A clinic or facility for: (a) Convalescent, custodial, educational or nursing care; (b) The aged, drug addicts or alcoholics; or (c) Rehabilitation; or 2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless: (a) The services are rendered on an emergency basis; and (b) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
VERMONT	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN NJ.**
Child	"Child" means the Covered Person's natural Child, adopted Child (or Child placed in the Covered Person's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Covered Person has legal guardianship (proof will be required). A Child must reside with the Covered Person in a parent-Child relationship and be eligible to be claimed as an exemption on the Covered Person's federal income tax return. NOTE: In the event the Covered Person shares physical custody of the Child with another parent or civil union partner, the requirement that the Child reside with the Covered Person will be waived.
Dependent	"Dependent" means a Covered Person's: 1. lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner. 2. unmarried Children under age 26. The age limitations will not apply to a Covered Person's unmarried Child who: 1. is incapable of self-sustaining employment by reason of a mental or physical disability that has been found to be a disability that qualifies or would qualify the child for benefits using the definitions, standards, and methodology in 20 C.F.R. Part 404, Subpart P; 2. became so incapable prior to attainment of the limiting age; and 3. is chiefly dependent upon the employee, member, subscriber, or policyholder for support and maintenance. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.
Full-Time	"Full-Time" means working for the Policyholder an average of at least 30 hours per week.
Injury	"Injury" means harm which results from an Accident. All injuries to the same Covered Person sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
VIRGINIA	
Dependent	"Dependent" means a Covered Person's: 1. lawful spouse, if not legally separated or divorced, or Domestic Partner. 2. unmarried Children under age 26. The age limitations will not apply to a Covered Person's unmarried Child who is incapable of self-support due to an intellectual disability or physical handicap. Proof of such handicap must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.
Federal Aviation Administration (FAA)	"Federal Aviation Administration (FAA)" means the national aviation authority of the United States of America that has the authority to regulate and oversee all aspects of civil aviation in the U.S.
Health Care Plan	"Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under: 1. Group or blanket insurance, whether on an insured or self-funded basis; 2. Hospital or medical service organizations on a group basis; 3. Health Maintenance Organizations on a group basis. 4. Group labor management plans; 5. Employee benefit organization plan; 6. Professional association plans on a group basis; or 7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.
Spouse	"Spouse" means lawful spouse, if not legally separated or divorced.
WYOMING	
Medically Necessary or Medical Necessity	Medically Necessary means: (A) A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that: (I) Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury; (II) Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury; (III) Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care; and (IV) Is not primarily for the convenience of the patient, physician or other health care provider. (B) A medical service, procedure or supply shall not be excluded from being a medical necessity under this section solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by: (I) Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or (II) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act

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LIMITATIONS & EXCLUSIONS

The Certificate does not cover any loss resulting **in whole or part from, or contributed to by, or as** a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under the Certificate by Additional Benefits:

Below Limitations & Exclusions are based on the TX Certificate of Insurance. Any state variations in the Limitations and Exclusions will shown below that Limitation & Exclusion. (The bolded "in whole or part from, or contributed to by, or as" statement above is not in the **Illinois** *Certificate.) (Limitations & Exclusions are entirely different for* **California** *- disregard all the limitations and exclusions below for CA and go to* **pages 46-47 for CA** *specific Limitations & Exclusions.) (Limitations & Exclusions were too different for* **Idaho** *- disregard all the limitations and exclusions below for ID and go to* **page 48 for ID** *specific Limitations & Exclusions.) (Limitations & Exclusions are entirely different for* **Missouri** *- disregard all the limitations and exclusions below for MO and go to* **pages 50-51** *for MO specific Limitations & Exclusions) (Limitations & Exclusions are entirely different for* **New Jersey** *- disregard all the limitations and exclusions below for NJ and go to* **pages 52-53 for NJ** *specific Limitations & Exclusions) (Limitations & Exclusions are entirely different for* **Vermont** *- disregard all the limitations and exclusions below for VT and go to* **pages 54-55** *for VT specific Limitations & Exclusions)* **Any reference to CA, KS, ID, MO, NJ, NM, PA & VT limitations and exclusions are only used for explaining coverage to current members and not for new sales.**

1. Suicide, intentional self-destruction, attempted intentional self-destruction or intentional self-inflicted Injury while sane or insane.

   (AL, AR, AZ, DC, DE, FL, GA, IA, IL, IN, KS, KY, LA, MI, MS, NC, ND, NE, NM, OH, OK, PA, RI, SC, TN, VA, WI, WV, & WY #1 exclusions replace this exclusion with the following #1 exclusion: Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane.)
2. War or any act of war, declared or undeclared.

   (**FL, NC & VA #2** exclusions replace this exclusion with the following #2 exclusion: War or any act of war, declared or undeclared. This does not apply to acts of terrorism).

   (**OK #2** exclusion is replaced on the Amendatory Rider as follows: War or any act of war, declared or undeclared when serving in the military or an auxiliary unit thereto.)
3. An Accident which occurs while the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro rata premium upon request.
5. Participation in a riot or insurrection;
6. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.

   (**GA** does not have this above #6 exclusion.)

   (**NC #6** exclusion replaces this exclusion with the following: Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery, unless as a result of domestic violence.)
7. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an Accidental external bodily injury or accidental food poisoning.

   (#7 exclusion above is the same as **GA's #6** exclusion.)
8. Disease or disorder of the body or mind.

   (#8 exclusion above is the same as **GA's #7** exclusion.)
9. Mental or nervous disorders, except as specifically provided in the Policy.

   (#9 exclusion above is the same as **GA's #8** exclusion.)
10. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.

    (#10 exclusion above is the same as **GA's #9** exclusion.)

    (**IL, KY & NC** do not have this above #10 exclusion.)
11. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician and not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.

    (#11 exclusion above is the same as **GA's #10** exclusion.)

    (**IL** does not have this above #11 exclusion.)

    (#11 exclusion above is the same as **KY's #10** exclusion.)

    (**LA** does not have this above #11 exclusion.)

    (**MI** removes this #11 exclusion through the Amendatory Rider and therefore this exclusion does not apply in MI.)

    (#11 exclusion above is the same as **NC's #10** exclusion.)

    (**NE** does not have this above #11 exclusion.)

    (**SC** does not have this above #11 exclusion. It was removed in the Amendatory Rider and does not apply to SC.)

Group Accident Insurance limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate, master policy, and any State Amendments or Endorsements for complete details.

12. Intoxication or being under the influence of any drug or narcotic.
    (#12 exclusion above is the same as **GA's #11** exclusion.)
    (#12 exclusion above is the same as **IL's #10** exclusion, however IL's #10 exclusion replaces the language above to the following: Intoxication as defined in the State where the Accident Occurred)
    (#12 exclusion above is the same as **KY's #11** exclusion.)
    (#12 exclusion above is the same as **LA's #11** exclusion, however LA's #11 exclusion replaces the language with the following: Injury caused by intoxication or being under the influence of narcotics unless administered on the advise of a Physician.)
    (**MI** removes this #12 exclusion through the Amendatory Rider and therefore this exclusion does not apply in MI.)
    (#12 exclusion above is the same as **NC's #11** exclusion.)
    (#12 exclusion above is the same as **NE's #11**, however the language for NE's #11 exclusion is the following: Being legally intoxicated or under the influence of any narcotic, illegal drugs, or controlled substance unless administered on the advice of the Covered Person's Physician.)
    (**SC** does not have this above #12 exclusion. It was removed in the Amendatory Rider and does not apply to SC.)
13. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
    (#13 exclusion above is the same as **GA's #12** exclusion.)
    (**IL** does not have this above #13 exclusion.)
    (#13 exclusion above is the same as **KY's #12** exclusion.)
    (**LA** does not have this above #13 exclusion.)
    (**MI** removes this #13 exclusion through the Amendatory Rider and therefore this exclusion does not apply in MI.)
    (#13 exclusion above is the same as **NC's #12** exclusion.)
    (**NE** does not have this above #13 exclusion.)
    (**SC** does not have this above #13 exclusion. It was removed in the Amendatory Rider and does not apply to SC.)
14. Driving under the influence of a controlled substance unless administered on the advice of a Physician;
    (#14 exclusion above is the same as **GA's #13** exclusion.)
    (**IL** does not have this above #14 exclusion.)
    (#14 exclusion above is the same as **KY's #13** exclusion.)
    (#14 exclusion above is the same as **LA's #12** exclusion.)
    (**MI** removes this #14 exclusion through the Amendatory Rider and therefore this exclusion does not apply in MI.)
    (#14 exclusion above is the same as **NC's #13** exclusion.)
    (#14 exclusion above is the same as **NE's #12** exclusion.)
    (**SC** does not have this above #14 exclusion. It was removed in the Amendatory Rider and does not apply to SC.)
15. Driving while Intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.
    (#15 exclusion above is the same as **GA's #14** exclusion)
    (**IL** does not have this above #15 exclusion.)
    (#15 exclusion above is the same as **KY's #14** exclusion.)
    (#15 exclusion above is the same as **LA's #13** exclusion.)
    (**MI** removes this #15 exclusion through the Amendatory Rider and therefore this exclusion does not apply in MI.)
    (#15 exclusion above is the same as **NC's #14** exclusion.)
    (#15 exclusion above is the same as **NE's #13** exclusion.)
    (**SC** does not have this above #15 exclusion. It was removed in the Amendatory Rider and does not apply to SC.)
16. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
    (#16 exclusion above is the same as **GA's #15** exclusion, however GA's #15 exclusion replaces the language above with the following: Commission or attempt to commit a felony, or an Accident that occurs while engaged in an illegal occupation.)
    (#16 exclusion above is the same as **IL's #11** exclusion.)
    (#16 exclusion above is the same as **KY's #15** exclusion.)
    (#16 exclusion above is the same as **LA's #14** exclusion.)
    (#16 exclusion above is the same as **NC's #15** exclusion.)
    (#16 exclusion above is the same as **NE's #14** exclusion, however NE's #14 exclusion language replaces the above language with the following: Commission or attempt to commit a felony, or being engaged in an illegal occupation.)

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

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17. Conditions that are not caused by a Covered Accident.
    (#17 exclusion above is the same as **GA's #16** exclusion.)
    (**IL** does not have this above #17 exclusion.)
    (#17 exclusion above is the same as **KY's #16** exclusion.)
    (#17 exclusion above is the same as **LA's #15** exclusion.)
    (#17 exclusion above is the same as **NC's #16** exclusion.)
    (#17 exclusion above is the same as **NE's #15** exclusion.)
18. Covered Expenses for which the Covered Person would not be responsible in the absence of the Policy.
    (#18 exclusion above is the same as **GA's #17** exclusion.)
    (#18 exclusion above is the same as **IL's #12** exclusion.)
    (#18 exclusion above is the same as **KY's #17** exclusion.)
    (#18 exclusion above is the same as **LA's #16** exclusion.)
    (#18 exclusion above is the same as **NC's #17** exclusion.)
    (#18 exclusion above is the same as **NE's #16** exclusion.)
19. Any treatment, service or supply not specifically covered by the Policy.
    (#19 exclusion above is the same as **GA's #18** exclusion.)
    (**IL** does not have this above #19 exclusion.)
    (#19 exclusion above is the same as **KY's #18** exclusion.)
    (#19 exclusion above is the same as **LA's #17** exclusion.)
    (#19 exclusion above is the same as **NC's #18** exclusion.)
    (#19 exclusion above is the same as **NE's #17** exclusion.)
20. Charges which are in excess of Usual, Reasonable and Customary charges.
    (#20 exclusion above is the same as **GA's #19** exclusion.)
    (#20 exclusion above is the same as **IL's #13** exclusion.)
    (#20 exclusion above is the same as **KY's #19** exclusion.)
    (#20 exclusion above is the same as **LA's #18** exclusion.)
    (#20 exclusion above is the same as **NC's #19** exclusion.)
    (#20 exclusion above is the same as **NE's #18** exclusion.)
21. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits.
    (#21 exclusion above is the same as **GA's #20** exclusion.)
    (#21 exclusion above is the same as **IL's #14** exclusion.)
    (#21 exclusion above is the same as **KY's #20** exclusion.)
    (#21 exclusion above is the same as **LA's #19** exclusion.)
    (#21 exclusion above is the same as **NC's #20** exclusion.)
    (#21 exclusion above is the same as **NE's #19** exclusion.)
22. Regular health check-ups;
    (#22 exclusion above is the same as **GA's #21** exclusion.)
    (#22 exclusion above is the same as **IL's #15** exclusion.)
    (#22 exclusion above is the same as **KY's #21** exclusion.)
    (#22 exclusion above is the same as **LA's #20** exclusion.)
    (#22 exclusion above is the same as **NC's #21** exclusion.)
    (#22 exclusion above is the same as **NE's #20** exclusion.)
23. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person, except with regard to a dentist.
    (AL, AR, DC, DE, FL, (GA's #22 exclusion), IA, (IL's #16 exclusion), IN, KS, (KY's #22 exclusion), (LA's #21 exclusion), MI, MS, (NC's #22 exclusion), ND, (NE's #21 exclusion), NM, OH, OK, PA, RI, SC, TN, VA, WI, WV, & WY #23 exclusions replace this exclusion with the following #23 exclusion: Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.)

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24. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
    (#24 exclusion is the same as **GA's #23** exclusion.)
    (#24 exclusion is the same as **IL's #17** exclusion.)
    (#24 exclusion is the same as **KY's #23** exclusion.)
    (#24 exclusion is the same as **LA's #22** exclusion.)
    (#24 exclusion is the same as **NC's #23** exclusion, however NC's #23 exclusion replaces the language in the exclusion with the following: Injuries paid for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to the final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Worker's Compensation Act.)
    (#24 exclusion is the same as **NE's #22** exclusion.)
    (**OH** does not have this above #24 exclusion.)
    (**KS #24** exclusion replaces the exclusion language with the following: Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder to the extent You are covered or required to be covered by the Workers' Compensation law. If you enter into a settlement giving up your right to recover future medical benefits under a Workers' Compensation law, the Policy will not pay those benefits that would have been payable in absence of that settlement.)
25. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
    (**GA** does not have this above #25 exclusion.)
    (#25 exclusion is the same as **IL's #18** exclusion.)
    (#25 exclusion is the same as **KY's #24** exclusion.)
    (#25 exclusion is the same as **LA's #23** exclusion.)
    (**NC** does not have this above #25 exclusion.)
    (#25 exclusion is the same as **NE's #23** exclusion.)
    (#25 exclusion is the same as **OH's #2**4 exclusion.)
    (**VA** does not have this above #25 exclusion.)
26. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
    (#26 exclusion above is the same as **GA's #24** exclusion.)
    (#26 exclusion above is the same as **IL's #19** exclusion.)
    (#26 exclusion above is the same as **KY's #25** exclusion.)
    (#26 exclusion above is the same as **LA's #24** exclusion.)
    (**LA's #26 exclusion** is not in TX or other certificates. LA's actual #26 exclusion is the following: Aggravation or re-injury of a prior injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician.)
    (#26 exclusion above is the same as **NC's #24** exclusion.)
    (#26 exclusion above is the same as **NE's #24** exclusion.)
    (#26 exclusion above is the same as **OH's #25** exclusion.)
    (#26 exclusion above is the same as **VA's #25** exclusion.)

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27. Participation in any motorized race or speed contest.
    (#27 exclusion above is the same as **GA's #25** exclusion.)
    (#27 exclusion above is the same as **IL's #20** exclusion.)
    (#27 exclusion above is the same as **KS's #28** exclusion.)
    (#27 exclusion above is the same as **KY's #26** exclusion.)
    (#27 exclusion above is the same as **LA's #25** exclusion.)
    (#27 exclusion above is the same as **NC's #25** exclusion.)
    (#27 exclusion above is the same as **NE's #25** exclusion, however, NE's #25 exclusion replaces the language of the exclusion with the following: Participation in any organized motorized race or speed contest.)
    (#27 exclusion above is the same as **OH's #26** exclusion.)
    (#27 exclusion above is the same as **VA's #26** exclusion.)
    (**KS #27** exclusion is different from above. KS #27 exclusion is: Travel or activity outside the United States.)
28. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.
    (#28 exclusion above is the same as **AZ's #29** exclusion.)
    (#28 exclusion above is the same as **GA's #26** exclusion.)
    (#28 exclusion above is the same as **IL's #21** exclusion.)
    (#28 exclusion above is the same as **KS's #29** exclusion.)
    (#28 exclusion above is the same as **KY's #27** exclusion.)
    (#28 exclusion above is the same as **LA's #27** exclusion.)
    (#28 exclusion above is the same as **NC's #26** exclusion.)
    (#28 exclusion above is the same as **NE's #26** exclusion.)
    (#28 exclusion above is the same as **OH's #27** exclusion.)
    (#28 exclusion above is the same as **VA's #27** exclusion.)
    (**AZ #28** exclusion is different than above. AZ #28 exclusion is the following: Aggravation or re-injury of a prior Injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician)
29. Treatment of a hernia whether or not caused by a Covered Accident.
    (#29 exclusion above is the same as **AZ's #30** exclusion.)
    (#29 exclusion above is the same as **GA's #27** exclusion.)
    (#29 exclusion above is the same as **IL's #22** exclusion, however IL's #22 exclusion replaces the exclusion with the following: Treatment of all types of hernias whether or not caused by a Covered Accident.)
    (#29 exclusion above is the same as **KS's #30** exclusion.)
    (#29 exclusion above is the same as **KY's #28** exclusion.)
    (#29 exclusion above is the same as **LA's #28** exclusion.)
    (#29 exclusion above is the same as **NC's #27** exclusion.)
    (#29 exclusion above is the same as **NE's #27** exclusion.)
    (#29 exclusion above is the same as **OH's #28** exclusion.)
    (#29 exclusion above is the same as **VA's #28** exclusion.)
30. Treatment of Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological or stress fractures, congenital weakness, whether or not caused by a Covered Accident.
    (#30 exclusion above is the same as **AZ's #31** exclusion.)
    (#30 exclusion above is the same as **GA's #28** exclusion.)
    (**IL** does not have this above #30 exclusion.)
    (#30 exclusion above is the same as **KS's #31** exclusion.)
    (#30 exclusion above is the same as **KY's #29** exclusion.)
    (#30 exclusion above is the same as **LA's #29** exclusion.)
    (#30 exclusion above is the same as **NC's #28** exclusion.)
    (#30 exclusion above is the same as **NE's #28** exclusion.)
    (#30 exclusion above is the same as **OH's #29** exclusion.)
    (#30 exclusion above is the same as **VA's #29** exclusion.)

31. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
    (#31 exclusion above is the same as **AZ's #32** exclusion.)
    (#31 exclusion above is the same as **GA's #29** exclusion.)
    (#31 exclusion above is the same as **IL's #23** exclusion.)
    (#31 exclusion above is the same as **KS's #32** exclusion.)
    (#31 exclusion above is the same as **KY's #30** exclusion.)
    (#31 exclusion above is the same as **LA's #30** exclusion.)
    (#31 exclusion above is the same as **NC's #29** exclusion.)
    (#31 exclusion above is the same as **NE's #29** exclusion.)
    (#31 exclusion above is the same as **OH's #30** exclusion.)
    (#31 exclusion above is the same as **VA's #30** exclusion.)
32. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.
    (#32 exclusion above is the same as **AZ's #33** exclusion.)
    (#32 exclusion above is the same as **GA's #30** exclusion.)
    (#32 exclusion above is the same as **IL's #24** exclusion.)
    (#32 exclusion above is the same as **KS's #33** exclusion.)
    (#32 exclusion above is the same as **KY's #31** exclusion.)
    (#32 exclusion above is the same as **LA's #31** exclusion.)
    (#32 exclusion above is the same as **NC's #30** exclusion.)
    (#32 exclusion above is the same as **NE's #30** exclusion.)
    (#32 exclusion above is the same as **OH's #31** exclusion.)
    (**TN #32** exclusion replaces the above exclusion language with the following: Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions unless such complications are the result of a Covered Accident.)
    (#32 exclusion above is the same as **VA's #31** exclusion.)
33. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in the Policy.
    (#33 exclusion above is the same as **AZ's #34** exclusion.)
    (#33 exclusion above is the same as **GA's #31** exclusion.)
    (#33 exclusion above is the same as **IL's #25** exclusion.)
    (#33 exclusion above is the same as **KS's #34** exclusion.)
    (#33 exclusion above is the same as **KY's #32** exclusion.)
    (#33 exclusion above is the same as **LA's #32** exclusion.)
    (#33 exclusion above is the same as **NC's #31** exclusion.)
    (#33 exclusion above is the same as **NE's #31** exclusion.)
    (#33 exclusion above is the same as **OH's #32** exclusion.)
    (#33 exclusion above is the same as **VA's #32** exclusion.)
34. Expense incurred for treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in the Policy.
    (#34 exclusion above is the same as **AZ's #35** exclusion.)
    (#34 exclusion above is the same as **GA's #32** exclusion.)
    (#34 exclusion above is the same as **IL's #26** exclusion.)
    (#34 exclusion above is the same as **KS's #35** exclusion.)
    (#34 exclusion above is the same as **KY's #33** exclusion.)
    (#34 exclusion above is the same as **LA's #33** exclusion.)
    (**NC** does not have this above #34 exclusion.)
    (#34 exclusion above is the same as **NE's #32** exclusion.)
    (#34 exclusion above is the same as **OH's #33** exclusion.)
    (#34 exclusion above is the same as **VA's #33** exclusion.)

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35. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under the Policy, and rendered within 6 months of the Accident;
    (#34 exclusion above is the same as **AZ's #36** exclusion.)
    (#34 exclusion above is the same as **GA's #33** exclusion.)
    (#34 exclusion above is the same as **IL's #27** exclusion.)
    (#34 exclusion above is the same as **KS's #36** exclusion.)
    (#34 exclusion above is the same as **KY's #34** exclusion.)
    (#34 exclusion above is the same as **LA's #34** exclusion.)
    (#34 exclusion above is the same as **NC's #32** exclusion.)
    (#34 exclusion above is the same as **NE's #33** exclusion.)
    (#34 exclusion above is the same as **OH's #34** exclusion.)
    (#34 exclusion above is the same as **VA's #34** exclusion.)
36. Treatment for Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
    (#36 exclusion above is the same as **AZ's #37** exclusion.)
    (#36 exclusion above is the same as **GA's #34** exclusion.)
    (#36 exclusion above is the same as **IL's #28** exclusion.)
    (#36 exclusion above is the same as **KS's #37** exclusion.)
    (#36 exclusion above is the same as **KY's #35** exclusion.)
    (#36 exclusion above is the same as **LA's #34** exclusion.)
    (#36 exclusion above is the same as **NC's #33** exclusion.)
    (#36 exclusion above is the same as **NE's #34** exclusion.)
    (#36 exclusion above is the same as **OH's #35** exclusion.)
    (#36 exclusion above is the same as **VA's #35** exclusion.)
37. Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;
    (#37 exclusion above is the same as **AZ's #38** exclusion.)
    (#37 exclusion above is the same as **GA's #35** exclusion.)
    (#37 exclusion above is the same as **IL's #29** exclusion.)
    (#37 exclusion above is the same as **KS's #38** exclusion.)
    (#37 exclusion above is the same as **KY's #36** exclusion.)
    (#37 exclusion above is the same as **LA's #36** exclusion.)
    (#37 exclusion above is the same as **NC's #34** exclusion.)
    (#37 exclusion above is the same as **NE's #35** exclusion.)
    (#37 exclusion above is the same as **OH's #36** exclusion.)
    (#37 exclusion above is the same as **VA's #36** exclusion.)
38. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
    (#38 exclusion above is the same as **AZ's #39** exclusion.)
    (#38 exclusion above is the same as **GA's #36** exclusion.)
    (#38 exclusion above is the same as **IL's #30** exclusion.)
    (#38 exclusion above is the same as **KS's #39** exclusion.)
    (#38 exclusion above is the same as **KY's #37** exclusion.)
    (#38 exclusion above is the same as **LA's #37** exclusion.)
    (#38 exclusion above is the same as **NC's #35** exclusion.)
    (#38 exclusion above is the same as **NE's #36** exclusion.)
    (#38 exclusion above is the same as **OH's #37** exclusion.)
    (#38 exclusion above is the same as **VA's #37** exclusion.)

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39. Travel in or upon:
    a) a snow mobile;
    b) a water jet ski;
    c) any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
    d) any off-road motorized vehicle not requiring licensing as a motor vehicle; when used for recreation competition.

    (AL, AR, (AZ #40 exclusion), DC, DE, FL, (GA #37 exclusion), IA, (IL #31 exclusion), IN, (KS #40 exclusion), (KY #38 exclusion), (LA #38 exclusion), MI, MS, (NC's #36 exclusion), ND, (NE #37 exclusion), NM, (OH #38 exclusion), OK, PA, RI, SC, TN, (VA #38 exclusion), WI, WV, & WY #39 exclusions replace this exclusion with the following #39 exclusion:

    Travel in or upon:
    a) a snowmobile;
    b) a water jet ski;
    c) any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
    d) any off-road motorized vehicle not requiring licensing as a motor vehicle.)

40. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    i. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    ii. While being used for any test or experimental purpose; or
    iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
    iv. While traveling in such Aircraft or device which is owned or leased by or on behalf of the Policyholder or any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
    v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    vi. An ultra light, hang-gliding, parachuting or bungee-cord jumping; Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a nonscheduled, private aircraft used for business or pleasure purposes.

    (#40 exclusion above is the same as **AZ's #41** exclusion.)
    (#40 exclusion above is the same as **GA's #38** exclusion.)
    (#40 exclusion above is the same as **IL's #32** exclusion.)
    (#40 exclusion above is the same as **KS's #41** exclusion.)
    (#40 exclusion above is the same as **KY's #39** exclusion.)
    (#40 exclusion above is the same as **LA's #39** exclusion.)
    (#40 exclusion above is the same as **NC's #37** exclusion.)
    (#40 exclusion above is the same as **NE's #38** exclusion.)
    (#40 exclusion above is the same as **OH's #39** exclusion.)
    (#40 exclusion above is the same as **VA's #39** exclusion.)

    (DC #40 exclusion replaces the above exclusion with the following:

    40. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
        i. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
        ii. While being used for any test or experimental purpose; or
        iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
        iv. while traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
        v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
        vi. An ultra light, hang-gliding, parachuting or bungee-cord jumping; Except as a fare paying passenger on a regularly scheduled commercial airline.)

    (**LA #40 exclusion** is actually the following: Treatment for an Injury that is caused by or results from a Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and: (i) the loss was caused by fire, heat, explosion, or other physical trauma which was a result of the release of nuclear energy; and (ii) the Covered Person was within a 25-mile radius of the site of the release either: 1) at the time of the release; or 2) within 24 hours of the start of the release;)

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41. Practice or play in any school or professional sports contest or competition.
    (#41 exclusion above is the same as **AZ's #43** exclusion.)
    (#41 exclusion above is the same as **GA's #39** exclusion.)
    (#41 exclusion above is the same as **IL's #33** exclusion.)
    (#41 exclusion above is the same as **KS's #42** exclusion.)
    (#41 exclusion above is the same as **KY's #40** exclusion.)
    (#41 exclusion above is the same as **NC's #38** exclusion.)
    (#41 exclusion above is the same as **NE's #39** exclusion.)
    (**NM** does not have this #41 exclusion.)
    (#41 exclusion above is the same as **OH's #40** exclusion.)
    (#41 exclusion above is the same as **VA"s #40** exclusion.)
42. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
    (#42 exclusion above is the same as **AZ's #44** exclusion.)
    (#42 exclusion above is the same as **GA's #40** exclusion.)
    (**IL** does not have this above #42 exclusion.)
    (#42 exclusion above is the same as **KS's #43** exclusion.)
    (#42 exclusion above is the same as **KY's #41** exclusion.)
    (#42 exclusion above is the same as **NC's #39** exclusion.)
    (#42 exclusion above is the same as **NE's #40** exclusion.)
    (#42 exclusion above is the same as **NM's #41** exclusion.)
    (#42 exclusion above is the same as **OH's #41** exclusion.)
    (#42 exclusion above is the same as **VA's #41** exclusion.)
    (**AZ #42** exclusion is the following: Treatment for an Injury that is caused by or results from a Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and: (i) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and (ii) The Covered Person was within a 25-mile radius of the site of the release either: 1) At the time of the release; or 2) Within 24 hours of the start of the release.)
43. Rest cures or custodial care;
    (#43 exclusion above is the same as **AZ's #45** exclusion.)
    (#43 exclusion above is the same as **GA's #41** exclusion.)
    (#43 exclusion above is the same as **IL's #34** exclusion.)
    (#43 exclusion above is the same as **KS's #44** exclusion.)
    (#43 exclusion above is the same as **KY's #42** exclusion.)
    (#43 exclusion above is the same as **NC's #40** exclusion.)
    (#43 exclusion above is the same as **NE's #41** exclusion.)
    (#43 exclusion above is the same as **NM's #42** exclusion.)
    (#43 exclusion above is the same as **OH's #42** exclusion.)
    (#43 exclusion above is the same as **VA's #42** exclusion.)
44. Prescription medicines unless specifically provided for under the Policy.
    (#44 exclusion above is the same as **AZ's #46** exclusion.)
    (#44 exclusion above is the same as **GA's #42** exclusion.)
    (#44 exclusion above is the same as **IL's #35** exclusion.)
    (#44 exclusion above is the same as **KS's #4**5 exclusion.)
    (#44 exclusion above is the same as **KY's #43** exclusion.)
    (#44 exclusion above is the same as **NC's #41** exclusion.)
    (#44 exclusion above is the same as **NE's #42** exclusion.)
    (#44 exclusion above is the same as **NM's #43** exclusion.)
    (#44 exclusion above is the same as **OH's #43** exclusion.)
    (#44 exclusion above is the same as **VA"s #43** exclusion.)

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45. Elective or Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
    (#45 exclusion above is the same as **AZ's #47** exclusion.)
    (#45 exclusion above is the same as **GA's #43** exclusion.)
    (#45 exclusion above is the same as **IL's #36** exclusion.)
    (#45 exclusion above is the same as **KS's #46** exclusion.)
    (#45 exclusion above is the same as **KY's #44** exclusion.)
    (#45 exclusion above is the same as **NC's #42** exclusion.)
    (#45 exclusion above is the same as **NE's #43** exclusion.)
    (#45 exclusion above is the same as **NM's #44** exclusion.)
    (#45 exclusion above is the same as **OH's #44** exclusion.)
    (#45 exclusion above is the same as **VA's #44** exclusion.)
46. Massage Therapy, Physical Therapy or Acupuncture / Acupressure Services, unless otherwise specifically allowed for in the Schedule of Benefits.
    (#46 exclusion above is the same as **AZ's #48** exclusion.)
    (#46 exclusion above is the same as **GA's #44** exclusion.)
    (#46 exclusion above is the same as **IL's #37** exclusion.)
    (#46 exclusion above is the same as **KS's #47** exclusion.)
    (#46 exclusion above is the same as **KY's #45** exclusion.)
    (#46 exclusion above is the same as **NC's #43** exclusion.)
    (#46 exclusion above is the same as **NE's #44** exclusion.)
    (#46 exclusion above is the same as **NM's #45** exclusion.)
    (#46 exclusion above is the same as **OH's #45** exclusion.)
    (#46 exclusion above is the same as **VA's #45** exclusion.)
47. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
    (#47 exclusion above is the same as **AZ's #49** exclusion.)
    (#47 exclusion above is the same as **GA's #45** exclusion.)
    (#47 exclusion above is the same as **IL's #38** exclusion.)
    (#47 exclusion above is the same as **KS's #48** exclusion.)
    (#47 exclusion above is the same as **KY's #46** exclusion.)
    (#47 exclusion above is the same as **NC's #44** exclusion.)
    (#47 exclusion above is the same as **NE's #45** exclusion.)
    (#47 exclusion above is the same as **NM's #46** exclusion.)
    (#47 exclusion above is the same as **OH's #46** exclusion.)
    (#47 exclusion above is the same as **VA's #46** exclusion.)

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LIMITATIONS & EXCLUSIONS - CA ONLY

BELOW ARE THE LIMITATIONS & EXCLUSIONS FROM CA CERTIFICATE AND PAGES 46-47 ONLY APPLY TO CA:

Below are CA Limitations and Exclusions are for explaining to current customers only. This is not for new sales.

The Policy and this Certificate does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under the Policy and this Certificate by Additional Benefits:

1. Is proximately caused by the Covered Person's own:
   (a) Intentionally self-inflicted Injury, suicide or any attempt thereat;
   (b) Commission or attempt to commit a felony;
   (c) Participation in a riot or insurrection;
2. Is proximately caused by:
   (a) Declared or undeclared war or act of war;
   (b) Aviation, except as specifically provided in the Policy and this Certificate;
   (c) Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

ADDITIONAL EXCLUSIONS

Benefits will not be paid for:

1. Normal health checkups;
2. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under the Policy and this Certificate, and rendered within 6 months of the Accident;
3. Services or treatment rendered by a Physician, nurse or any other person who is:
   (a) Employed or retained by the Policyholder; or
   (b) Who is the Covered Person or a member of his immediate family;
4. Charges which:
   (a) The Covered Person would not have to pay if he did not have insurance; or
   (b) Are in excess of Usual, Reasonable and Customary charges.
5. An Injury that is caused by flight in:
   (a) An aircraft, except as a fare-paying passenger;
   (b) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
   (c) An ultra light, hang-gliding, parachuting or bungee-cord jumping;
6. Travel in or upon:
   (a) A snowmobile;
   (b) Any two or three wheeled motor vehicle;
   (c) Any off-road motorized vehicle not requiring licensing as a motor vehicle;
7. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
8. Injury that is:
   (a) The result of the Covered Person being Intoxicated. ("Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs); or
   (b) Caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a physician;
9. Any Sickness, except infection which occurs directly from an Accidental cut or wound or diagnostic tests or treatment, or ingestion of contaminated food;

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

Group Accident Insurance limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate, master policy, and any State Amendments or Endorsements for complete details.

10. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan;
11. Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
12. Elective treatment or surgery, health treatment, or examination where no Injury is involved;
13. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
14. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
15. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;
16. Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
17. Any loss which is covered by state or federal worker's compensation, employers liability, occupational disease law, or similar laws;
18. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
19. Rest cures or custodial care (Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
20. The repair or replacement of existing dentures, partial dentures, braces or fixed or removable bridges;
21. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
22. Orthopedic appliances which are used mainly to protect an Injury so that a covered student can take part in interscholastic or intercollegiate sports;
23. Hernia of any kind; or any bacterial infection that was not caused by an Accidental cut or wound;
24. Prescription medicines unless specifically provided for under the Policy and this Certificate.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

Group Accident Insurance limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate, master policy, and any State Amendments or Endorsements for complete details.

LIMITATIONS & EXCLUSIONS - ID ONLY

BELOW ARE THE LIMITATIONS & EXCLUSIONS FROM ID CERTIFICATE AND PAGE 48 ONLY APPLY TO ID:

Below are ID Limitations and Exclusions are for explaining to current customers only. This is not for new sales.

This Certificate does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under this Certificate by Additional Benefits:

1. Suicide, attempted suicide or intentionally self-inflicted Injury, while sane or insane.
2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
5. Participation in a felony, riot or insurrection;
6. Disease or disorder of the body or mind.
7. Mental or nervous disorders, except as specifically provided in this Policy.
8. Injury caused by or contributed to or resulting from alcohol or drug addiction.
9. Conditions that are not caused by a Covered Accident.
10. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
11. Charges which Are in excess of Usual, Reasonable and Customary charges.
12. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
13. Regular health check ups;
14. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
15. Injuries paid under State or Federal Workers' Compensation law, Employer's liability or occupational disease laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
16. Injuries paid under motor vehicle no- fault law.
17. Injuries paid under Medicare or other governmental program (except Medicaid)
18. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 6 months of the Accident;
19. Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;
20. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
21. Elective or Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child;
22. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;
23. Rest cures or custodial care;
24. Pregnancy, except for complications of Pregnancy;
25. Prescription medicines unless specifically provided for under this Policy;
26. Aviation

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

Group Accident Insurance limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate, master policy, and any State Amendments or Endorsements for complete details.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

Group Accident Insurance limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate, master policy, and any State Amendments or Endorsements for complete details.

LIMITATIONS & EXCLUSIONS - MO ONLY

BELOW ARE THE LIMITATIONS & EXCLUSIONS FROM MO CERTIFICATE AND PAGES 50-51 ONLY APPLY TO MO:

Below are MO Limitations and Exclusions are for explaining to current customers only. This is not for new sales.

This Certificate does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under this Certificate by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane.
2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
5. Participation in a riot or insurrection;
6. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
7. Disease or disorder of the body or mind.
8. Mental or nervous disorders, except as specifically provided in this Policy.
9. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
10. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician and not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
11. Intoxication or being under the influence of any drug or narcotic
12. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
13. Driving under the influence of a controlled substance unless administered on the advice of a Physician;
14. Driving while Intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs
15. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
16. Conditions that are not caused by a Covered Accident.
17. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
18. Any treatment, service or supply not specifically covered by this Policy.
19. Loss resulting from participation in any activity not specifically covered by this Policy.
20. Charges which are in excess of Usual, Reasonable and Customary charges.
21. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
22. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
23. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
24. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
25. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay in the absence of this insurance
26. Participation in any motorized race or speed contest.
27. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.
28. Treatment of a hernia whether or not caused by a Covered Accident.
29. Treatment of Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological or stress fractures, congenital weakness, whether or not caused by a Covered Accident.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

Group Accident Insurance limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate, master policy, and any State Amendments or Endorsements for complete details.

30. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
31. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.
32. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
33. Expense incurred for treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in this Policy.
34. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 6 months of the Accident;
35. Treatment for Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
36. Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;.
37. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
38. Travel in or upon:
    (a) A snowmobile;
    (b) A water jet ski
    (c) Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
    (d) Any off-road motorized vehicle not requiring licensing as a motor vehicle;
    when used for recreation competition.
39. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    i. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    ii. While being used for any test or experimental purpose; or
    iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
    iv. while traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
    v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    vi. An ultra light, hang-gliding, parachuting or bungee-cord jumping;
    Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a nonscheduled, private aircraft used for business or pleasure purposes.
40. Practice or play in any school or professional sports contest or competition.
41. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
42. Rest cures or custodial care;
43. Prescription medicines unless specifically provided for under this Policy.
44. Elective or Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
45. Massage Therapy, Physical Therapy or Acupuncture/Acupressure Services, unless otherwise specifically allowed for in the schedule of benefits.
46. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

LIMITATIONS & EXCLUSIONS - NJ ONLY

BELOW ARE THE LIMITATIONS & EXCLUSIONS FROM MO CERTIFICATE AND PAGES 52-53 ONLY APPLY TO NJ:

Below are NJ Limitations and Exclusions are for explaining to current customers only. This is not for new sales.

This Certificate does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under this Certificate by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
5. Participation in a riot or insurrection;
6. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
7. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an Accidental external bodily injury or accidental food poisoning.
8. Disease or disorder of the body or mind.
9. Mental or nervous disorders, except as specifically provided in this Policy.
10. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
11. Any loss sustained or contracted as a consequence of the covered person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a physician.
12. Any loss to which a contributing cause was the covered person's commission of or attempt to commit a felony or to which a contributing cause was the covered person's engagement in an illegal occupation.
13. Conditions that are not caused by a Covered Accident.
14. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
15. Any treatment, service or supply not specifically covered by this Policy.
16. Charges which are in excess of Usual, Reasonable and Customary charges.
17. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
18. Regular health check ups;
19. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
20. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
21. Participation in any motorized race or speed contest.
22. Treatment of a hernia whether or not caused by a Covered Accident.
23. Treatment of Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological or stress fractures, congenital weakness, whether or not caused by a Covered Accident.
24. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
25. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions unless he result of an accident.
26. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
27. Expense incurred for treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in this Policy.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

Group Accident Insurance limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate, master policy, and any State Amendments or Endorsements for complete details.

28. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 6 months of the Accident;
29. Treatment for Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
30. Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;
31. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
32. Travel in or upon:
    (a) A snowmobile;
    (b) A water jet ski
    (c) Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
    (d) Any off-road motorized vehicle not requiring licensing as a motor vehicle;
33. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    i. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    ii. While being used for any test or experimental purpose; or
    iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
    iv. while traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
    v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    vi. An ultra light, hang-gliding, parachuting or bungee-cord jumping;
    Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a nonscheduled, private aircraft used for business or pleasure purposes.
34. Practice or play in any school or professional sports contest or competition.
35. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
36. Rest cures or custodial care;
37. Prescription medicines unless specifically provided for under this Policy.
38. Elective or Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
39. Massage Therapy, Physical Therapy or Acupuncture/Acupressure Services, unless otherwise specifically allowed for in the schedule of benefits.
40. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

Group Accident Insurance limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate, master policy, and any State Amendments or Endorsements for complete details.

LIMITATIONS & EXCLUSIONS - VT ONLY

BELOW ARE THE LIMITATIONS & EXCLUSIONS FROM ID CERTIFICATE AND PAGES 54-55 ONLY APPLY TO VT:

Below are VT Limitations and Exclusions are for explaining to current customers only. This is not for new sales.

This Certificate does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under this Certificate by Additional Benefits:

1. 1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane.
2. 2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
5. Participation in a riot or insurrection;
6. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
7. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an Accidental external bodily injury or accidental food poisoning.
8. Disease or disorder of the body or mind.
9. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
10. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
11. Conditions that are not caused by a Covered Accident.
12. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
13. Any treatment, service or supply not specifically covered by this Policy.
14. Charges which are in excess of Usual, Reasonable and Customary charges.
15. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
16. Regular health check ups;
17. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
18. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
19. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
20. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay
21. Participation in any motorized race or speed contest.
22. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.
23. Treatment of a hernia whether or not caused by a Covered Accident.
24. Treatment of Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological or stress fractures, congenital weakness, whether or not caused by a Covered Accident.
25. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
26. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
27. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 6 months of the Accident;
28. Treatment for Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and <u>not</u> for new sales.)

Group Accident Insurance limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate, master policy, and any State Amendments or Endorsements for complete details.

29. Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;.
30. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
31. Travel in or upon:
    (a) A snowmobile;
    (b) A water jet ski
    (c) Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
    (d) Any off-road motorized vehicle not requiring licensing as a motor vehicle;
32. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    i. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    ii. While being used for any test or experimental purpose; or
    iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
    iv. while traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
    v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    vi. An ultra light, hang-gliding, parachuting or bungee-cord jumping;
    Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a nonscheduled, private aircraft used for business or pleasure purposes.
33. Practice or play in any school or professional sports contest or competition.
34. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
35. Rest cures or custodial care;
36. Prescription medicines unless specifically provided for under this Policy.
37. Elective or Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
38. Massage Therapy, Physical Therapy or Acupuncture/Acupressure Services, unless otherwise specifically allowed for in the schedule of benefits.
39. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

The provisions below are for all Group Accident Insurance states underwritten by United State Fire Insurance Company to United Business Association (based on the TX Certificate of Insurance). Some states may have variations or added provisions. Those variations and added provisions will be located between pages 75-105. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

PROVISION[2]	PROVISION DESCRIPTION[2]
EFFECTIVE DATES OF INSURANCE	All provisions below are based on the TX Version of the Effective Dates of Insurance Provision Section. Any State Variations will list the state & Page # to view
Policy Effective Date	Policy Effective Date. The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.
Covered Person's Effective Date	Covered Person's Effective Date: A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of: 1. The Effective Date of the Policy; or 2. The day He becomes eligible, according to the referenced date shown in the Application/Enrollment Form Newborn Children Coverage: We will pay benefits for a newborn Child from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate. Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by You prior to the birth of the Child, whether or not such agreement is enforceable. The following states **replace** the Covered Person's Effective Date provision above with the following language below: **AL, AZ, CA, DC, DE, GA, IA, IL, IN, KY, LA, MI, MS, ND, NJ, NM, OH, OK, PA, RI, SC, TN, VA, VT, WI, WV & WY**. Covered Person's Effective Date: A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of: 1. The Effective Date of the Policy; or 2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form Newborn Children Coverage: We will pay benefits for a newborn Child from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by You prior to the birth of the Child, whether or not such agreement is enforceable. **Arkansas** has a variation based on the AR Certificate. **See page 71** for variation of provision language. **Florida** has a variation based on the FL Certificate. **See page 75** for variation of provision language. **Idaho** has a variation based on the ID Certificate. **See page 80** for variation of provision language. **Kansas** has a variation based on the KS Certificate. **See page 83** for variation of provision language. **Missouri** has a variation based on the MO Certificate. **See page 86** for variation of provision language. **Nebraska** has a variation based on the NE Certificate. **See page 88** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 90** for variation of provision language.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

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PROVISION[2]	PROVISION DESCRIPTION[2]
EFFECTIVE DATES OF INSURANCE	All provisions below are based on the TX Version of the Effective Dates of Insurance Provision Section. Any State Variations will list the state & Page # to view
Newborn Child Exception	Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are insured as a Dependent under the Policy and this Certificate. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse. Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of You are a party to a suit in which you seek to adopt the Child. A notice of suit for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate. Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child. The following states **replace** the provision with the following language below: **AL, AZ, AR, CA, DC, DE, FL, IA, KS, KY, LA, MI, MS, ND, NE, NJ, NM, OK, PA, RI, SC, TN, VA, VT, WI, WV & WY**. Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are insured as a Dependent under the Policy and this Certificate. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse. Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in Your home. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate. Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child. **Georgia** has a variation based on the GA Certificate. **See page 78** for variation of provision language. **Idaho** has a variation based on the ID Certificate. **See page 80** for variation of provision language. **Illinois** has a variation based on the IL Certificate. **See page 81** for variation of provision language. **Indiana** has a variation based on the IN Certificate. **See page 82** for variation of provision language. **Missouri** has a variation based on the MO Certificate. **See page 86** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 90** for variation of provision language. **Ohio** has a variation based on the OH Certificate. **See page 93** for variation of provision language.
TERMINATION DATE OF INSURANCE	All provisions below are based on the TX Version of the Termination Date of Insurance Provision Section. Any State Variations will list the state & Page # to view
Policy Termination Date	Policy Termination Date Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination. The Policy terminates automatically on the earlier of: 1. The Policy Termination Date shown in this Policy; or 2. The premium due date if premiums are not paid when due subject to any grace period. Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid. The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date. The Policyholder and the Company may terminate this Policy at any time by written mutual consent. If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference. **Florida** has a variation based on the FL Certificate. **See page 76** for variation of provision language. **Georgia** has a variation based on the GA Certificate. **See page 78** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 91** for variation of provision language. **Virginia** has a variation based on the VA Certificate. **See page 96** for variation of provision language.

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PROVISION[2]	PROVISION DESCRIPTION[2]
TERMINATION DATE OF INSURANCE	All provisions below are based on the TX Version of the Termination Date of Insurance Provision Section. Any State Variations will list the state & Page # to view
Covered Person's Termination Date	Covered Person's Termination Date Insurance for a Covered Person under the Policy and this Certificate will end on the earliest of: 1. The Date the Policy Terminates; 2. The date He is no longer in an Eligible Class as described in the Policy; 3. The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of: (a) The date the premium is fully earned; or (b) The Expiration Date of the Certificate. This does not include Reserve or National Guard duty for training; 4. The end of the period for which the last premium contribution is made; or 5. The date the Covered Person requests, in writing, that his/her coverage be terminated. **California** has a variation based on the CA Certificate. **See page 71** for variation of provision language. **Georgia** has a variation based on the CA Certificate. **See page 78** for variation of provision language. **Virginia** has a variation based on the VA Certificate. **See page 96** for variation of provision language.
Dependent's Termination Date	Dependent's Termination Date A Dependent's coverage under the Policy and this Certificate ends on the earliest of: 1. The date the Policy terminates; or 2. The date the Covered Person's coverage ends; or 3. The date the Dependent is no longer a Dependent; or 4. The last day of the period for which premiums have been paid. **California** has a variation based on the CA Certificate. **See page 71** for variation of provision language. **Kentucky** has a variation based on the KY Certificate. **See page 84** for variation of provision language. **Virginia** has a variation based on the CA Certificate. **See page 96** for variation of provision language.
Extension of Benefits	EXTENSION OF BENEFITS Termination of coverage will not affect any claim that began while the coverage was in force. If a Covered Person was Totally Disabled on the date coverage would otherwise terminate, benefits will be continued until: 1) 90 days elapse; 2) The date that the maximum amount of benefits have been paid; 3) The date that the Covered Person ceases to be Totally Disabled; or 4) The effective date of replacement coverage of equivalent or greater benefits provided by a succeeding carrier, but only if the replacement coverage covers the Injury causing the Total Disability without limitation due to the Injury having commenced prior to the effective date of the replacement coverage; whichever first occurs. Only benefits for the Injury causing the Total Disability are continued. No benefits are payable with respect to any other Injury. **Florida** has a variation based on the FL Certificate. **See page 76** for variation of provision language. **Missouri** has a variation based on the FL Certificate. **See page 87** for variation of provision language. **Vermont** has a variation based on the VT Certificate. **See page 94** for variation of provision language. **AL, AR, AZ, CA, DC, DE, GA, IA, ID, IL, IN, KS, KY, LA, MI, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, VA, WI, WV, & WY** do **not** have this provision in the Certificate of Insurance.

The following states have **additional Termination Provisions**. See below for state-specific Additional Provision and Page Numbers:

Refund of Unearned Premiums PG 80 IDAHO

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PROVISION[2]	PROVISION DESCRIPTION[2]
PREMIUM PROVISIONS	All provisions below are based on the TX Version of the Premium Provision Section. Any State Variations will list the state & Page # to view
Premiums	PREMIUMS: The Company provides insurance in return for premium payments. The premium showed in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy or this Certificate with regard to change. Failure by the Policyholder or Certificateholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid. The Company has the right to rely upon the accuracy of the Policyholder's calculations and to require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date. **Virginia** has a variation based on the VA Certificate. **See page 96** for variation of provision language.
Grace Period	GRACE PERIOD: A grace period of 31 days will be allowed for the payment of premium after the first premium. During the grace period, this Policy will be in force and We will continue to be liable for valid claims for covered expenses incurred before the end of the grace period. If at least 90 days prior to the premium due date We send written notice to the Policyholder of Our intent not to renew this Policy, the grace period will not apply to any period after the date the non-renewal is to be effective. If the Policyholder tells Us in writing that the Policy will not be renewed, the grace period will not apply after the date the non-renewal is to be effective. If the premium is not paid by the end of the grace period, the Policy will terminate on that date. The Policyholder will continue to be liable to Us for any unpaid premiums in addition to the premiums for the grace period. The following states **replace** the Grace Period provision above with the following language below: **AL, AZ, DC, DE, GA, IA, ID, IL, IN, KS, KY, LA, MI, MO, MS, ND, NJ, NM, OH, OK, PA, RI, SC, TN, VT, WI, WV & WY**. GRACE PERIOD: A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Policyholder or certificate holder pays all the premiums due by the last day of the grace period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Policy and this Certificate. Coverage will end if the premium is not paid by the end of the grace period. **California** has a variation based on the CA Certificate. **See page 72** for variation of provision language. **Florida** has a variation based on the FL Certificate. **See page 76** for variation of provision language. **Virginia** has a variation based on the VA Certificate. **See page 96** for variation of provision language.

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PROVISION[2]	PROVISION DESCRIPTION[2]
PREMIUM PROVISIONS	All provisions below are based on the TX Version of the Premium Provision Section. Any State Variations will list the state & Page # to view
Changes in Premium Rate	Changes in Premium Rate Not less than 60 days before the date on which a premium rate increase takes effect, We shall give written notice to the Policyholder of: 1) the amount of the increase; and 2) the date on which the increase is to take effect. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date. The following states **replace** the Change in Premium Rate provision above with the following language below: **AL, AZ, DC, DE, ID, IL, IN, KS, KY, MI, MO, MS, NJ, OH, OK, PA, RI, SC, TN, VT, WI, WV & WY**. Changes in Premium Rate The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy and this Certificate. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date. **California** has a variation based on the CA Certificate. **See page 72** for variation of provision language. **Florida** has a variation based on the FL Certificate. **See page 76** for variation of provision language. **Georgia** has a variation based on the GA Certificate. **See page 79** for variation of provision language. **Iowa** has a variation based on the IA Certificate. **See page 83** for variation of provision language. **Louisiana** has a variation based on the LA Certificate. **See page 84** for variation of provision language. **Missouri** has a variation based on the MO Certificate. **See page 87** for variation of provision language. **New Mexico** has a variation based on the NM Certificate. **See page 90** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 91** for variation of provision language. **North Dakota** has a variation based on the ND Certificate. **See page 92** for variation of provision language. **Vermont** has a variation based on the VT Certificate. **See page 94** for variation of provision language. **Virginia** has a variation based on the VA Certificate. **See page 97** for variation of provision language.
Reinstatement	Reinstatement The Policy and this Certificate may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if the Policyholder or Certificateholder submits written application to the Company, the Company accepts the application and the Policyholder Certificateholder makes payment of all overdue premiums. **North Carolina** has a variation based on the NC Certificate. **See page 91** for variation of provision language.

The following states have **additional Premium Provisions**. See below for state-specific Additional Provision and Page Numbers:

Newly-Acquired Subsidiaries	PG 87 MISSOURI
Newly-Acquired Subsidiaries	PG 90 NEW MEXICO

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PROVISION[2]	PROVISION DESCRIPTION[2]
CLAIMS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
Notice of Claim	NOTICE OF CLAIM: Written notice of death or injury must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given at Our administrative office as shown on the cover page or to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Covered Person's name and address. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1. it can be shown that it was not possible within reason to submit notice within the 30 day period; and 2. it is further shown that notice was given as soon as possible. **California** has a variation based on the CA Certificate. **See page 73** for variation of provision language. **Louisiana** has a variation based on the LA Certificate. **See page 84** for variation of provision language.
Claim Forms	CLAIM FORMS: When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss. **California** has a variation based on the CA Certificate. **See page 73** for variation of provision language. **Georgia** has a variation based on the GA Certificate. **See page 79** for variation of provision language. **New Jersey** has a variation based on the NJ Certificate. **See page 89** for variation of provision language. **Virginia** has a variation based on the VA Certificate. **See page 97** for variation of provision language.
Proof of Loss	PROOF OF LOSS: Written proof of loss must be furnished to Us in the case of a claim for loss for which this Certificate provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by us. In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss. If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1. it can be shown that it was not possible within reason to submit notice within the 90 day period; and 2. it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. **California** has a variation based on the CA Certificate. **See page 73** for variation of provision language. **Florida** has a variation based on the FL Certificate. **See page 76** for variation of provision language. **New Jersey** has a variation based on the NJ Certificate. **See page 89** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 92** for variation of provision language. **Ohio** has a variation based on the OH Certificate. **See page 93** for variation of provision language. **Vermont** has a variation based on the VA Certificate. **See page 94** for variation of provision language. **Virginia** has a variation based on the VA Certificate. **See page 97** for variation of provision language.

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PROVISION[2]	PROVISION DESCRIPTION[2]
CLAIMS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
Timely Filing of Claims	TIMELY FILING OF CLAIMS: All claims for benefits under this Certificate must be submitted to Us no more than 90 days from the date of service or date of death. If a claim is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. The following states **replace** the Timely Filing of Claims provision above with the following language below: **AL, AR, AZ, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MI, MO, MS, NC, ND, NE, NM, OK, PA, RI, SC, TN, VT, WI, WV & WY**. TIMELY FILING OF CLAIMS: All claims for benefits under this Certificate must be submitted to Us no more than 90 days from the date of service or date of death. **California** does not have this provision in the CA Certificate. **New Jersey** does not have this provision in the NJ Certificate. **Ohio** does not have this provision in the OH Certificate. **Virginia** does not have this provision in the VA Certificate.
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Benefits due under this Certificate for a loss, other than a loss for which this Certificate provides installments, will be paid immediately upon receipt of due written proof of such loss. Subject to written proof of loss, all accrued benefits for loss for which this Certificate provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits. We will notify a claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the date We receive all items, statements and forms we require in order to secure final proof of loss. If We are unable to accept or reject the claims within this time, We will notify the claimant within the 15 business days. This notice will give the reason we need additional time. We will notify the claimant within 45 days after the notice that the claim is accepted or rejected. If We reject the claim, the notice provided will state the reasons the claim was rejected. The following states **replace** the Time of Payment of Claims provision above with the following language below: **AL, AR, AZ, DC, DE, IA, ID, KS, KY, MI, MO, NC, ND, NE, NM, OH, OK, PA, RI, SC, TN, VA, VT, WI, WV & WY**. TIME OF PAYMENT OF CLAIMS: Benefits due under this Certificate for a loss, other than a loss for which this Certificate provides installments, will be paid immediately upon receipt of due written proof of such loss. Subject to written proof of loss, all accrued benefits for loss for which this Certificate provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits. **California** has a variation based on the CA Certificate. **See page 73** for variation of provision language. **Florida** has a variation based on the FL Certificate. **See page 77** for variation of provision language. **Georgia** has a variation based on the GA Certificate. **See page 79** for variation of provision language. **Illinois** has a variation based on the IL Certificate. **See page 81** for variation of provision language. **Indiana** has a variation based on the AL Certificate. **See page 82** for variation of provision language. **Louisiana** has a variation based on the LA Certificate. **See page 84** for variation of provision language. **Mississippi** has a variation based on the MS Amendatory Rider. **See page 86** for variation of provision language. **New Jersey** has a variation based on the NJ Certificate. **See page 89** for variation of provision language.

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PROVISION[2]	PROVISION DESCRIPTION[2]
CLAIMS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
Payment of Claims	PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Policy entitled 'General Policy Provisions'. To receive proceeds, a beneficiary must be living on the earlier of the following dates: the date the Company receives proof of the loss of life; or the 10th day after the death. If the Covered Person dies, any unpaid accrued benefits will be payable according to the assignment on the claim, if any. If there is no valid assignment, unpaid accrued benefits will be payable in accordance with the beneficiary designation, if any, or to the Covered Person's estate. If any benefit becomes payable to the Covered Person's estate, or to someone who is a minor or otherwise not competent to give a valid release, We may pay such benefit up to $1,000.00 to any relative by blood, or connection by marriage of the Covered Person or beneficiary who is deemed by Us to be equitably entitled to it. Benefits will be payable to the Texas Department of Human Services if any of the following conditions exist: 1. The Covered Person or, if a minor, the Covered Person's parent has executed an assignment of benefits by reason of making application for or receiving benefits for medical assistance under the Medical Assistance Act of 1967 of the State of Texas, as amended; 2. The minor Covered Person's parent is: a. A possessory conservator of said minor Covered Person under an order issued by a Texas court or is not entitled to possession or access to said minor Covered Person; and b. Required by court order or court approved agreement to pay child support; or 3. The Texas Department of Human Services is paying benefits on behalf of the minor Covered Person under Chapter 31 or 32 of the Human Resources Code. We must receive written notice of any of the above conditions and the assignment created by them by an attachment to the claim form originally submitted for benefits under the Policy. Benefits for a minor may be paid on behalf of the minor to a person who is not the Covered Person if an order issued by a court of competent jurisdiction in Texas names such person the managing conservator of the minor. Such benefits will be payable to the managing conservator provided the conservator has submitted: 1. Written notice to Us with the claim application that such person is the Covered Person's managing conservator; and 2. A certified copy of a court order establishing the person as managing conservator or other evidence designed by rule of the State Board of Insurance that such person qualifies to be paid the benefits. Such requirements shall not apply in the cases of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the parent of a minor Covered Person where the parent has paid any portion of a medical bill that would be covered under the terms of the Policy. The following states **replace** the Payment of Claims provision above with the following language below: **AL, AR, AZ, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MI, MS, NC, ND, NE, NJ, NM, OH, OK, PA, RI, SC, TN, VA, WI, WV & WY**. PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Certificate. All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Certificate. If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment. Any other accrued benefits which are unpaid at a Covered Person's death may, at Our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person. **California** has a variation based on the CA Certificate. **See page 73** for variation of provision language. **Mississippi** has a variation based on the MS Amendatory Rider. **See page 85** for variation of provision language. **Missouri** has a variation based on the MO Certificate. **See page 87** for variation of provision language. **Vermont** has a variation based on the VT Certificate. **See page 94** for variation of provision language.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

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PROVISION[2]	PROVISION DESCRIPTION[2]
CLAIMS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
Designation or Change of Beneficiary	DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order: 1. Beneficiaries designated in writing by the Covered Person for this Certificate on file with the Policyholder, if any, otherwise; 2. Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise; 3. In equal shares to the members of the first surviving class of those that follow, if any: a) a Covered Person's lawful spouse, if not legally divorced, or Domestic Partner; b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or c) a Covered Person's parents, whether natural, step or adoptive; or d) a Covered person's Sisters or Brothers, otherwise. 4. The estate of the Covered Person. A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt. A Dependent's beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Covered Person's estate. The following states **have a slight variation on #3(a)** of the Designation or Change of Beneficiary provision above: **AL, AR, AZ, DC, DE, IA, IN, KS, KY, LA, MI, MO, MS. NC, ND, NE. NJ, NM, OH, OK, PA, RI, SC, TN, VA, WI, WV & WY**. 3. a) a Covered Person's lawful spouse, if not legally divorced, or Domestic Partner; it is **replaced** with: a) a Covered Person's lawful spouse, if not legally **separated or** divorced, or Domestic Partner; **California** has a variation based on the CA Certificate. **See page 74** for variation of provision language. **Florida** has a variation based on the FL Certificate. **See page 77** for variation of provision language. **Georgia** has a variation based on the GA Certificate. **See page 79** for variation of provision language. **Idaho** has a variation based on the ID Certificate. **See page 81** for variation of provision language. **Illinois** has a variation based on the IL Certificate. **See page 82** for variation of provision language. **Vermont** has a variation based on the VT Certificate. **See page 95** for variation of provision language.
Conditional Claim Payment	CONDITIONAL CLAIM PAYMENT: If a Covered Person incurs expenses for Injuries received in a covered Accident, and in Our opinion a third party may be liable, We will pay benefits if: 1. The Covered Person first agrees in writing to refund the lesser of: (a) The amount We actually paid for such expenses; or (b) The amount actually received from the third party for such expenses; and 2. The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, prior to Our payment of benefits under this Certificate, if the third party's liability is satisfied in an amount less than the benefits payable under this Certificate, We will pay the difference. **California** does not have this provision in the CA Certificate. **Georgia** does not have this provision in the GA Certificate. **Michigan** has a variation based on the MI Amendatory Rider. **See page 85** for variation of provision language. **Missouri** does not have this provision in the MO Certificate. **Nebraska** has a variation based on the NE Certificate. **See page 88** for variation of provision language. **New Jersey** does not have this provision in the NJ Certificate. **North Carolina** does not have this provision in the NC Certificate. **Virginia** does not have this provision in the VA Certificate.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

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PROVISION[2]	PROVISION DESCRIPTION[2]
CLAIMS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
Exposure and Disappearance	EXPOSURE AND DISAPPEARANCE: A Covered Person will be presumed to have died due to covered Injuries, if while insurance is in effect He suffers Covered Loss due to exposure to the elements. A Covered Person will be presumed to have died, if, while insurance is in effect and after the forced landing, stranding, sinking or wrecking of a covered vehicle: 1. He disappears; and 2. His body is not found within a year of the Accident; and 3. a valid death certificate or other legal proof of death is issued by a court of appropriate jurisdiction. **Georgia** does not have this provision in the GA Certificate.
Physical Examination and Autopsy	PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy. (Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.) The following language **(Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.)** under Physical Examination and Autopsy are **NOT** in these state Certificates under this Provision: **DC, ID, IL, IN, KS, KY, LA, MO, NC, NE, NJ, NM, OH, TN, VA & VT.** **California** has a variation based on the CA Certificate. **See page 74** for variation of provision language.
Recovery of Overpayment	RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods. 1. A request for lump sum payment of the amount overpaid or paid in error or 2. Reduction of any proceeds payable under this Certificate by the amount overpaid or paid in error. **California** does not have this provision in the CA Certificate. **Kansas** does not have this provision in the KS Certificate. **Missouri** has a variation based on the MO Certificate. **See page 88** for variation of provision language. **Nebraska** has a variation based on the NE Certificate. **See page 88** for variation of provision language. **Oklahoma** has a variation based on the OK Amendatory Rider. **See page 93** for variation of provision language.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

The provisions below are for all Group Accident Insurance states underwritten by United State Fire Insurance Company to United Business Association (based on the TX Certificate of Insurance). Some states may have variations or added provisions. Those variations and added provisions will be located between pages 71-105. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.

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PROVISION[2]	PROVISION DESCRIPTION[2]
CLAIMS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
Recovery of Benefits	RECOVERY OF BENEFITS: We reserve the right to recover from a Covered Person any benefits We have paid to him for injuries: 1. Received in a covered Accident; and 2. Which are covered under: (a) workers' compensation or similar statutory remedies available under law; or (b) Any employer's liability Insurance. It will be assumed that the Covered Person is in receipt of such benefits unless he gives us proof such benefits have been denied to him. "Recovery" means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for all losses caused by the Injury. **California** does not have this provision in the CA Certificate. **DC** has a variation based on the DC Certificate. **See page 75** for variation of provision language. **Florida** does not have this provision in the FL Certificate. **Georgia** has a variation based on the GA Certificate. **See page 79** for variation of provision language. **Illinois** does not have this provision in the IL Certificate. **Kansas** does not have this provision in the KS Certificate. **Missouri** does not have this provision in the MO Certificate. **New Jersey** does not have this provision in the NJ Certificate. **North Carolina** does not have this provision in the NC Certificate.
Subrogation	SUBROGATION: The Policyholder is required to investigate and prosecute all valid claims that it may have against third parties arising out of any claim for which benefits were paid by this Policy. The Policyholder shall account to the Company for all amounts recovered. If the Policyholder fails to pursue any action against a third party and the Company has made benefit payments under this Policy, the Company will be subrogated to all of the Policyholder's rights to make recoveries. However, the Company's Subrogation right is secondary to the Policyholder's right to be fully compensated for its damages. The Policyholder is required to cooperate fully and do all things necessary and required for the Company to pursue any action to recover against the third party; the scope of the Policyholder's cooperation shall include, without limitation, the execution of a Subrogation receipt or assignment in favor of the Company and the granting of authorization to the Company to commence litigation or other legal proceedings in the name of the Policyholder to seek recoveries from third parties. The Company agrees to pay its portion of the Policyholder's attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this Policy pursuant to its Subrogation right. The following states **replace** the Payment of Claims provision above with the following language below: **AL, AR, AZ, DC, DE, IA, IL, KS, KY, MS, ND, NJ, NM, OH, OK, PA, RI, SC, TN, WI, WV & WY**. SUBROGATION: If We have paid benefits to a Covered Person for Injuries received in a covered Accident, and in Our opinion a third party may be liable, We will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents. **California** does not have this provision in the CA Certificate. **Florida** has a variation based on the FL Certificate. **See page 77** for variation of provision language. **Georgia** has a variation based on the GA Certificate. **See page 79** for variation of provision language. **Idaho** does not have this provision in the ID Certificate. **Kansas** does not have this provision in the KS Certificate. **Louisiana** has a variation based on the LA Certificate. **See page 84** for variation of provision language. **Michigan** has a variation based on the MI Amendatory Rider. **See page 85** for variation of provision language. **Missouri** does not have this provision in the MO Certificate. **Nebraska** has a variation based on the NE Certificate. **See page 88** for variation of provision language. **New Jersey** does not have this provision in the NJ Certificate. **North Carolina** does not have this provision in the NC Certificate. **Virginia** does not have this provision in the VA Certificate.

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PROVISION[2]	PROVISION DESCRIPTION[2]
CLAIMS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
Legal Actions	LEGAL ACTIONS: All Policy terms will be interpreted under the laws of the state in which the Policy and this Certificate was issued. No legal action may be brought to recover on the Policy and this Certificate within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished. **Alabama** has a variation based on the AL Amendatory Rider. **See page 71** for variation of provision language. **California** has a variation based on the CA Certificate. **See page 74** for variation of provision language. **Florida** has a variation based on the FL Certificate. **See page 77** for variation of provision language. **Kansas** has a variation based on the KS Certificate. **See page 83** for variation of provision language. **Vermont** has a variation based on the KS Certificate. **See page 95** for variation of provision language.

The following states have **additional Claims Provisions**. See below for state-specific Additional Provision and Page Numbers:

Payment of Claims: Other Benefits	PG 73 CALIFORNIA
Time Limit on Certain Defenses	PG 74 CALIFORNIA
Medical Review Requirements	PG 74 CALIFORNIA
Errors Related To Your Coverage	PG 83 KANSAS
Right to Reimbursement	PG 82 ILLINOIS
Claims Experience	PG 98 VIRGINIA

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PROVISION[2]	PROVISION DESCRIPTION[2]
GENERAL PROVISIONS	All provisions below are based on the TX Version of the General Provision Section. Any State Variations will list the state & Page # to view
Entire Contract Changes	ENTIRE CONTRACT; CHANGES: The Policy, this Certificate, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at Our option, may also be made a part of this contract. All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested. No change in the Policy or this Certificate will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy and this Certificate. No agent may change the Policy or this Certificate or waive any of its provisions. **California** has a variation based on the CA Certificate. **See page 75** for variation of provision language. **Georgia** has a variation based on the GA Certificate. **See page 80** for variation of provision language. **Louisiana** has a variation based on the LA Certificate. **See page 85** for variation of provision language. **New Jersey** has a variation based on the NJ Certificate. **See page 89** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 92** for variation of provision language. **Ohio** has a variation based on the OH Certificate. **See page 93** for variation of provision language. **Virginia** has a variation based on the VA Certificate. **See page 98** for variation of provision language.
Workers's Compensation Insurance	WORKERS' COMPENSATION INSURANCE: The Policy and this Certificate is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.
Records Maintained	RECORDS MAINTAINED: The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person's insurance under the Policy and this Certificate. We shall be permitted to examine the Policyholder's records relating to coverage under this Certificate. Examination may occur at any reasonable time up to the later of: 1. The two year period after the expiration of the Policyholder's coverage; or 2. The final adjustment and settlement of all claims under the Policyholder's coverage. **North Carolina** has a variation based on the NC Certificate. **See page 92** for variation of provision language.
Reporting Requirements	REPORTING REQUIREMENTS: The Policyholder or its authorized agent must report to us, by the premium due date: 1. The names of all persons insured on the Effective Date of this Certificate; 2. The names of all persons who are insured after the Effective Date of the Policy and this Certificate; 3. The names of those persons whose insurance has terminated; and 4. Additional information required as agreed to by us and the Policyholder.
Certificates of Insurance	CERTIFICATES OF INSURANCE: A certificate of insurance will be delivered to the Policyholder for delivery to each Covered Person. Each certificate will list the benefits, conditions and limits of the Certificate. It will state to whom the benefits will be paid.
Policy Termination	POLICY TERMINATION: We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date. **Georgia** has a variation based on the GA Certificate. **See page 80** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 92** for variation of provision language.

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PROVISION[2]	PROVISION DESCRIPTION[2]
GENERAL PROVISIONS	All provisions below are based on the TX Version of the General Provision Section. Any State Variations will list the state & Page # to view
Conformity with State Statutes	CONFORMITY WITH STATE STATUTES: Any provision of the Policy and this Certificate in conflict on its effective date with the laws of the State of Issue indicated on the front page of the Policy and this Certificate is amended to conform to the minimum requirements of such laws. **Nebraska** has a variation based on the NE Certificate. **See page 89** for variation of provision language. **Vermont** has a variation based on the VT Certificate. **See page 95** for variation of provision language.
Other Coverage with Us	OTHER COVERAGE WITH US: At any one time each Covered Person may have only one Certificate issued by Us having coverage similar to that described in the Policy and this Certificate. If we find He has more than one such Certificate, coverage will be provided under the plan that has been in force for the longer period of time. We will refund premiums paid for all other Certificates for concurrent periods of coverage.
Clerical Error	CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.
Assignment	ASSIGNMENT: No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment. **California** has a variation based on the CA Certificate. **See page 75** for variation of provision language.
Insolvency	INSOLVENCY: The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Policy and this Certificate.
Non-Participating	NON-PARTICIPATING: The Policy and this Certificate is non-participating. It does not share in the Company's profits or surplus earnings.
Waiver	WAIVER: Failure of the Company to strictly enforce its rights under the Policy and this Certificate at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

The following states have **additional General Provisions**. See below for state-specific Additional Provision and Page Numbers:

New Entrants	PG 78	FLORIDA
Payment of Premiums	PG 89	NEW JERSEY
Independent Review	PG 95	VERMONT
Grievance Procedures	PGS 102-105	WYOMING

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STATE VARIATIONS AND ADDITIONS

PROVISION VARIATIONS

In this section of the agent guide (pages 71-105), all of the state variations that are different from the provisions listed between pages 56-69 are detailed. The descriptions are done alphabetically. You will find all variations or additions for that state within each state section. Some states may carry over to multiple pages depending on the amount of variations or additions.

Make sure that BEFORE you discuss the right coverage, terms, definitions, limitations and exclusions with a client that you are reviewing the state-specific version so that you are giving the member the correct information for their home state.

QUICK STATE PAGES REFERENCE

*These states are no longer being marketed. The definitions for these states are **ONLY** for explanation purposes for current members and not for any NEW sales.

PROVISION[2]	PROVISION DESCRIPTION[2]
ALABAMA	
CLAIMS PROVISIONS	
Legal Actions	The LEGAL ACTIONS provision is revised based on the Amendatory Rider as follows: All Policy terms will be interpreted under the laws of the state in which this Policy was issued. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after six (6) years from the time written Proof of Loss is required to be furnished.
ARKANSAS	
EFFECTIVE DATES OF INSURANCE	
Covered Person's Effective Date	Covered Person's Effective Date: A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of: 1. The Effective Date of the Policy; or 2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form **The Newborn Children Coverage provision is amended based on the Amendatory Rider as follow**s: Newborn Children Coverage: We will pay benefits for a newborn Child from the moment of birth. You must give Us notice within 90 days of the birth of the Child. If notice is not given within 90 days, coverage for the newborn Child will terminate. Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by You prior to the birth of the Child, whether or not such agreement is enforceable.
CALIFORNIA	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN CA**.
TERMINATION DATE OF INSURANCE	
Policy Termination Date	Covered Person's Termination Date Insurance for a Covered Person will end on the earliest of: 1. The date He is no longer in an Eligible Class. 2. The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of: (a) The date the premium is fully earned; or (b) The Expiration Date of the Policy and this Certificate. This does not include Reserve or National Guard duty for training; 3. The end of the period for which the last premium contribution is made; or 4. The date the Policy and this Certificate is terminated; or 5. The date the Covered Person requests, in writing, that his/her coverage be terminated.
Covered Person's Termination Date	Covered Person's Termination Date Insurance for a Covered Person will end on the earliest of: 1. The date He is no longer in an Eligible Class. 2. The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of: (a) The date the premium is fully earned; or (b) The Expiration Date of the Policy and this Certificate. This does not include Reserve or National Guard duty for training; 3. The end of the period for which the last premium contribution is made; or 4. The date the Policy and this Certificate is terminated; or 5. The date the Covered Person requests, in writing, that his/her coverage be terminated.
Dependent's Termination Date	Dependent's Termination Date A Dependent's coverage ends on the earliest of: 1. The date the Policy terminates; or 2. The date the Covered Person's coverage ends; or 3. The date the Dependent is no longer a Dependent; or 4. The last day of the period for which premiums have been paid.

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PROVISION[2]	PROVISION DESCRIPTION[2]
CALIFORNIA	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN CA**.
PREMIUM PROVISIONS	
Grace Period	GRACE PERIOD: Unless not less than five days prior to the premium due date we have delivered to the Insured or have mailed to the Insured's last address as shown by our records written notice of our intention not to renew the Policy and this Certificate beyond the period for which the premium has been accepted, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).
Changes in Premium Rate	Changes in Premium Rate: The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Policyholder's most recent address in Our records. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
SCOPE OF COVERAGE	
Coordination of Benefits Provision	Coordination of Benefits Provision: If a Covered Person is insured for Benefits under the Policy and this Certificate, and is also covered for these Benefits under one or more other Plans, the benefits payable under the Policy and this Certificate will be coordinated with the benefits payable under all other Plans. Coordination of Benefits will be used to determine the benefits payable for a Covered Person for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of (1) and (2) below would exceed those Allowable Expenses: 1. The benefits that would be payable under the Policy and this Certificate without coordination; and 2. The benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans. The benefits that would be payable under the Policy and this Certificate for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of: 1. Those required benefits; and 2. All the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses. Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them. However, the benefits of another Plan will be ignored when the benefits of the Policy and this Certificate are determined if: 1. The Benefit Determination Rules would require the Policy and this Certificate to determine its benefits before that Plan; and 2. The other Plan has a provision that coordinates its benefits with those of the Policy and this Certificate and would, based on its rules, determine its benefits after the Policy and this Certificate. When Coordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a Covered Person, each benefit that would be payable in the absence of Coordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of the Policy and this Certificate. We reserve the right to release to or obtain from any other insurance company or other organization or person, any information that we or it needs for the purpose of the Coordination of Benefits, provided the proper authorization is received allowing Us to do so. When payments that should have been made under the Policy and this Certificate based on the terms of this provision have been made under any other Plans, We have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under the Policy and this Certificate. We will be released from all liability under the Policy and this Certificate to the extent of these payments. When an overpayment has been made by us, at any time, We will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as We may determine.

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PROVISION[2]	PROVISION DESCRIPTION[2]
CALIFORNIA	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN CA**.
CLAIMS PROVISIONS	
Notice of Claim	NOTICE OF CLAIM: Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the Policy and this Certificate, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured or Covered Person to us at our administrative office listed on the cover-page of the Policy and this Certificate, or to our authorized agent, with information sufficient to identify the Insured or Covered Person, shall be deemed notice to us.
Claim Forms	CLAIM FORMS: Upon our receipt of a notice of claim, we will furnish to the claimant such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy and this Certificate as to proof of loss upon submitting, within the time fixed in the Policy and this Certificate for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.
Proof of Loss	PROOF OF LOSS: Written proof of loss must be furnished to us in the case of a claim for loss for which the Policy and this Certificate provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us. In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss. If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Benefits payable under the Policy and this Certificate for any loss other than loss for which the Policy and this Certificate provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy and this Certificate provides periodic payment will be paid Monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.
Payment of Claims	PAYMENT OF CLAIMS: Benefits for a Covered Person's loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such benefit shall be payable to the estate of the Covered Person. Any other accrued benefits unpaid at the Covered Person's death may, at our option, be paid either to such beneficiary or to such estate. All other Benefits will be payable to the Covered Person. If any benefits under the Policy and this Certificate shall be payable to the estate of a Covered Person, or to a Cover Person or beneficiary who is a minor or otherwise not competent to give a valid release, we may pay such Benefit, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment. Subject to any written direction of a Covered Person in the application or otherwise all or a portion of any benefits provided by the Policy and this Certificate on account of hospital, nursing, medical, or surgical services may, at our option and unless the Covered Person requests otherwise in writing not later than the time of filing proofs of that loss, be paid directly to the person or persons having paid for the hospitalization or medical or surgical aid, or to the hospital or person rendering those services; but it is not required that the service be rendered by a particular hospital or person.
Payment of Claims: Other Benefits	PAYMENT OF CLAIMS: OTHER BENEFITS: All other benefits will be paid to the Covered Person, if he is living, if not, we will pay his beneficiary or his estate.

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CALIFORNIA	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN CA**.
CLAIMS PROVISIONS	
Designation or Change of Beneficiary	CHANGE OF BENEFICIARY: (Applicable only if an Accidental Death or Dismemberment benefit is provided) The Insured can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change which a Covered Person may make unless the designation of beneficiary is irrevocable or otherwise required by law.
Physical Examination & Autopsy	PHYSICAL EXAMINATION AND AUTOPSY: We, at our own expense, shall have the right and opportunity to examine the person of the Covered Person when and as often as it may reasonably require during the pending of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.
Time Limit of Certain Defenses	TIME LIMIT ON CERTAIN DEFENSES: After the Policy has been in force for a period of three years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Covered Persons eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made. No claim for loss incurred after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made:
Legal Actions	LEGAL ACTIONS: No action at law or in equity shall be brought to recover benefits under the Policy and this Certificate less than 60 days after written proof of loss has been furnished as required by the Policy and this Certificate. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.
Medical Review Requirements	MEDICAL REVIEW REQUIREMENTS A Covered Person may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance if he or she believes that we have improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under the Covered Person's coverage that has been denied, modified, or delayed by us, in whole or in part because the service is not Medically Necessary. The IMR process is in addition to any other procedures or remedies that may be available. There is no application or processing fee of any kind for an IMR. The Covered Person has the right to provide information in support of the request for an IMR. We must provide the Covered Person with an IMR application form together with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause a Covered Person to forfeit any California statutory right to pursue legal action against us regarding the disputed health care service. It should be noted that we do not believe any such California statutory right exists which is applicable to it. For more information regarding the IMR process, or to request an application form, please contact us. Eligibility. The California Department of Insurance will review the Covered Person's application for an IMR to confirm that: 1. a. The provider has recommended a health care service as Medically Necessary. b. The Covered Person has received urgent care or emergency services that a provider determined was Medically Necessary; or c. The Covered Person has been seen by a provider for the diagnosis or treatment of the medical condition for which he or she seeks independent review. 2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary; and 3. The Covered Person filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If the grievance requires expedited review, the Covered Person may bring it immediately to the attention of the California Department of Insurance. It may waive the requirement that the Covered Person follow the plan's grievance process in extraordinary and compelling cases. If a case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination as to whether or not the care is Medically Necessary. The Covered Person will receive a copy of the assessment made. If the IMR determines the service is Medically Necessary, we will provide benefits for the health care service. For non-urgent cases, the IMR organization designated by the California Department of Insurance must provide its determination within 30 days of receipt of the Covered Person's application and supporting documents. For urgent cases involving an imminent and serious threat to a Covered Person's health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Covered Person's health, the IMR organization must provide its determination within three business days.

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CALIFORNIA	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN CA**.
GENERAL PROVISIONS	
Entire Contract Changes	ENTIRE CONTRACT; CHANGES: The Policy and this Certificate, the Certificate, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy and this Certificate shall be valid until approved in by one of our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy and this Certificate or the Certificate or to waive any of its provisions. All statements made by the Policyholder or by a Covered Person in the absence of fraud, be deemed a representation and not a warranty. No such statement shall (avoid the insurance or reduce the benefits under the Policy or) be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder or Covered Person, except a fraudulent misstatement, be used at all to void the Policy or this Certificate after it has been in force for three years from the date of its issue, nor shall any such statement of any person eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the policy) commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.
Assignment	ASSIGNMENT: No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment. Assignment of a hospitalization or medical or surgical aid expenses to the person or persons furnishing the hospitalization or medical or surgical aid will not be prohibited or restricted.
DISTRICT OF COLUMBIA	
CLAIMS PROVISIONS	
Recovery of Benefits	RECOVERY OF BENEFITS: We reserve the right to recover from a Covered Person any benefits We have paid to him for injuries: 1. Received in a covered Accident; and 2. Which are covered under: (a) workers' compensation or similar statutory remedies available under law; or (b) Any employer's liability Insurance. It will be assumed that the Covered Person is in receipt of such benefits unless he gives us proof such benefits have been denied to him.
FLORIDA	
EFFECTIVE DATES OF INSURANCE	
Covered Person's Effective Date	Covered Person's Effective Date: A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of: 1. The Effective Date of the Policy; or 2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form Newborn Children Coverage: We will pay benefits for a newborn Child from the moment of birth. A Child born to a Covered Person or Covered Dependent will automatically become insured as a Dependent. The effective date of coverage will be the date of birth. Coverage will be to the same extent as provided for other covered dependent Children. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by You prior to the birth of the Child, whether or not such agreement is enforceable.

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PROVISION[2]	PROVISION DESCRIPTION[2]
FLORIDA	
TERMINATION OF INSURANCE	
Policy Termination Date	Policy Termination Date: Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination. The Policy terminates automatically on the earlier of: 1. 1) The Policy Termination Date shown in this Policy; or 2. 2) The premium due date if premiums are not paid when due subject to any grace period. Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums
Extension of Benefits	Extension of Benefits In the event of the total disability of a Covered Person at the date of termination of the Policy or Certificate We will provide an extension of benefits for 90 days, for Covered Expenses incurred during the period of disability prior to the Policy termination.
PREMIUM PROVISIONS	
Grace Period	GRACE PERIOD: The Policy has a 31 day grace period. This provision means that if a premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, the policy will stay in force. If the premium is not paid by the end of the grace period, the Policy will terminate on that date.
Changes in Premium Rate	Changes in Premium Rate The Company may change the premium rates from time to time with at least 45 days advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy and this Certificate. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
CLAIMS PROVISIONS	
Proof of Loss	PROOF OF LOSS: Written proof of loss must be furnished to Us in the case of a claim for loss for which this Certificate provides periodic payment contingent upon continuing loss within 180 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by us. In case of claim for any other loss, proof must be furnished within 180 days after the date of such loss. If the proof of loss is not submitted within 180 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1. it can be shown that it was not possible within reason to submit notice within the 180 day period; and 2. it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

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PROVISION[2]	PROVISION DESCRIPTION[2]
FLORIDA	
CLAIMS PROVISIONS	
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss. We will reimburse all claims or any portion of any claim from the Covered Person or the Covered Person's assignee, for payment under the Policy, within 45 days after We receive the claim. If a claim or a portion of a claim is contested by Us, the Covered Person or the Covered Person's assignee shall be notified, in writing, that the claim is contested or denied, within 45 days after We receive the claim. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. We, upon receipt of the additional information requested from the Covered Person or the Covered Person's assignee, will pay or deny the contested claim or portion of the contested claim within 60 days. We will pay or deny any claim no later than 120 days after We receive the claim. Payment will be treated as being made on the date a draft or other valid instrument which is equivalent to payment is placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments will bear simple interest at the rate of 10 percent per year. Upon written notice by the Covered Person, We will investigate any claim of improper billing by a Physician, Hospital or other health care provider. We will determine if the Covered Person was properly billed for only those procedures and services that the Covered Person actually received. If We determine that the Covered Person has been improperly billed, We will notify the Covered Person and the provider of our findings and We will reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notice by the Covered Person, We will pay to the Covered Person 20 percent of the amount of the reduction up to $500.
Designation or Change of Beneficiary	DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order: 1. Beneficiaries designated in writing by the Covered Person for this Certificate on file with the Policyholder, if any, otherwise; 2. Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise; 3. In equal shares to the members of the first surviving class of those that follow, if any: a) a Covered Person's lawful spouse, if not legally separated or divorced, or Domestic Partner; b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or c) a Covered Person's parents, whether natural, step or adoptive; or d) a Covered person's Sisters or Brothers, otherwise. 4. The estate of the Covered Person. A Covered Person may change his/her beneficiary designation from time to time by giving written notice to the Policyholder. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt. A Dependent's beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Covered Person's estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.
Subrogation	SUBROGATION: If We have paid benefits to a Covered Person for an Injury, and in Our opinion a third party may be liable, We will be subrogated to the extent of such payment and to all rights of the Covered Person regarding recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever is necessary to transfer His rights to Us. We will exercise such rights on His behalf. The Covered Person further agrees to furnish Us with all relevant information and documents. In no case will we receive an amount greater than the total amounts of benefits We have paid for such Injury.
Legal Actions	LEGAL ACTIONS: All Policy terms will be interpreted under the laws of the state of Florida. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after the expiration of the applicable statute of limitations.

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PROVISION[2]	PROVISION DESCRIPTION[2]
FLORIDA	
GENERAL PROVISIONS	
New Entrants	NEW ENTRANTS: All new members in the classes eligible for insurance will be added to such class for which they are eligible.
GEORGIA	
EFFECTIVE DATES OF INSURANCE	
Newborn Child Exception	Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are insured as a Dependent under the Policy and this Certificate. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse. Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the earlier of the date of placement for adoption in Your home or the date of final decree of adoption. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate. Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child.
TERMINATION DATE OF INSURANCE	
Policy Termination Date	Policy Termination Date Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination. The Policy terminates automatically on the earlier of: 1. 1) The Policy Termination Date shown in this Policy; or 2. 2) The premium due date if premiums are not paid when due subject to any grace period. Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid. The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 60 days prior to such date. The Policyholder and the Company may terminate this Policy at any time by written mutual consent. If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.
Covered Person's Termination Date	Covered Person's Termination Date Insurance for a Covered Person under the Policy and this Certificate will end on the earliest of: 1. The Date the Policy Terminates; 2. The date He is no longer in an Eligible Class as described in the Policy; 3. The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of: (a) The date the premium is fully earned; or (b) The Expiration Date of the Certificate. This does not include Reserve or National Guard duty for training; 4. The end of the period for which the last premium contribution is made; or 5. The date the Covered Person requests, in writing, that his/her coverage be terminated. If a Covered Person ceases to be Actively at Work due to an authorized family or medical leave, coverage may be continued for the full period of the leave not to exceed 12 months from the date the Covered Person was last Actively at Work. All required premiums must continue to be paid when due.

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PROVISION[2]	PROVISION DESCRIPTION[2]
GEORGIA	
PREMIUM PROVISIONS	
Change in Premium Rate	Changes in Premium Rate The Company may change the premium rates from time to time with at least 60 days advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy and this Certificate. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
CLAIMS PROVISIONS	
Claim Forms	CLAIM FORMS: When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 10 working days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Benefits due under the Policy for a loss, other than a loss for which the Policy provides installments, will be paid upon receipt of due written proof of such loss. We shall, within 15 working days after such receipt, mail payment for such benefits or notice which states the reasons for failing to pay the claim, in whole or in part, and which gives the Covered Person a written itemization of any information needed to process the claim or any portions thereof which are not being paid. Where We dispute a portion of the claim, any undisputed portion shall be paid. When all of the information needed to process the claim has been received, We shall then have 15 working days to either mail payment for the claim or a notice denying it, in whole or in part, giving the Covered Person the reasons for such denial. We shall pay interest equal to 18% per annum on the benefits due for failure to comply with this provision.
Designation or Change of Beneficiary	DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order: 1. Beneficiaries designated in writing by the Covered Person for this Policy on file with the Policyholder, if any, otherwise; 2. In equal shares to the members of the first surviving class of those that follow, if any: a) a Covered Person's lawful spouse, if not legally divorced, or Domestic Partner; b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or c) a Covered Person's parents, whether natural, step or adoptive; or d) a Covered person's Sisters or Brothers, otherwise. 3. The estate of the Covered Person. A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt. A Dependent's beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Covered Person's estate.
Right of Recovery / Subrogation	RIGHT OF RECOVERY / SUBROGATION: If You or your covered dependent has a claim for damages from a third party or parties for any illness or injury for which benefits are payable under this plan, We may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical covered medical expenses under this plan, but shall not include nonmedical items. Money received for future medical care or pain and suffering may not be recovered. Our right of recovery may include compromise settlements. You or your attorney must inform Us of any legal action or settlement agreement at least ten days prior to settlement or trial. We will then notify you of the amount it seeks to recover for covered benefits paid. Our recovery may be reduced by the pro-rata share of your attorney's fees and expenses of litigation.

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PROVISION[2]	PROVISION DESCRIPTION[2]
GEORGIA	
GENERAL PROVISIONS	
Entire Contract Changes	ENTIRE CONTRACT; CHANGES: The Policy, this Certificate, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at Our option, may also be made a part of this contract. In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of the group policy, all statements made by the Policyholder shall be deemed representations and not warranties, and no statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the Policyholder, a copy of which has been furnished to the Policyholder; All statements made by the Covered Person are also deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 6 months from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested. Such contestability of a Certificate holder's coverage is in actuality a denial of claims and not rescission for rescission is only of the master group policy. No change in the Policy or this Certificate will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy and this Certificate. No agent may change the Policy or this Certificate or waive any of its provisions.
Policy Termination	POLICY TERMINATION: We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 60 days prior to such premium due date.
IDAHO	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN ID**.
EFFECTIVE DATES OF INSURANCE	
Covered Person's Effective Date	Covered Person's Effective Date: A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of: 1. The Effective Date of the Policy; or 2. The day He becomes eligible, according to the referenced date shown in the Application/ Enrollment Form. A Covered Person's newborn Child will automatically become insured as a Dependent from the moment of birth for an initial period of 60 days. An adopted newborn Child Placed with the Covered Person within 60 days of the adopted Child's date of birth will be insured as a Dependent from the moment of birth for an initial period of 60 days. An adopted Child Placed with the Covered Person more than 60 days after the Child's birth will be insured as a Dependent for an initial period of 60 days from the date the Child is so Placed. Coverage will be to the same extent as is provided for other Covered Dependent Children. In the event additional premium is required for such newborn or adopted child, then the insurance will terminate 60 days from the date of birth or Placement for adoption unless written request to continue insurance is made to Us within 60 days from the date of birth or Placement for the purpose for adoption. Any additional premium must be paid after the initial 60 day period, and within the next 31 days following receipt by the Covered Person of a billing for such required additional premium.
Newborn Child Exception	Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are insured as a Dependent under this Policy. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse. Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child.
TERMINATION DATE OF INSURANCE	
Refund of Unearned Premiums	REFUND OF UNEARNED PREMIUMS: If a Covered Person, Covered Person's estate or entity cancels the Policy for any reason, We shall refund the pro rata portion of the unused collected premium to the beginning of the next monthly billing cycle.

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PROVISION[2]	PROVISION DESCRIPTION[2]
IDAHO	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN ID**.
CLAIMS PROVISIONS	
Designation or Change of Beneficiary	DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order: 1. Beneficiaries designated in writing by the Covered Person for this Certificate on file with the Policyholder, if any, otherwise; 2. Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise; 3. In equal shares to the members of the first surviving class of those that follow, if any: a) a Covered Person's lawful spouse, if not legally separated or divorced; b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or c) a Covered Person's parents, whether natural, step or adoptive; or d) a Covered person's Sisters or Brothers, otherwise. 4. The estate of the Covered Person. A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt. A Dependent's beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Covered Person's estate.
ILLINOIS	
EFFECTIVE DATES OF INSURANCE	
Newborn Child Exception	Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are insured as a Dependent under the Policy and this Certificate. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse. Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in Your home. A Child who is in the custody of the Covered Person, pursuant to an interim court order of adoption or placement of adoption, whichever comes first, vesting temporary care of the Child in the Covered Person, is an adopted Child, regardless of whether a final order granting adoption is ultimately issued. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate. Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child.
SCOPE OF COVERAGE	
Facility of Payment	FACILITY OF PAYMENT: Another plan may pay a Benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. Any amount so paid will be considered a Benefit under this plan. We will not be liable for such payment after it is made. Whenever used in this provision:
CLAIMS PROVISIONS	
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss. Claims not paid within 30 days following Our receipt of proper proof of loss shall entitle the Covered Person to interest at the rate of 9% per annum from the 30th day after receipt of such proof of loss to the date of the late payment.

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PROVISION[2]	PROVISION DESCRIPTION[2]
ILLINOIS	
CLAIMS PROVISIONS	
Designation or Change of Beneficiary	DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order: 1. Beneficiaries designated in writing by the Covered Person for this Certificate on file with the Policyholder, if any, otherwise; 2. Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise; 3. In equal shares to the members of the first surviving class of those that follow, if any: a) a Covered Person's lawful spouse, if not legally separated or divorced, or Domestic Partner; b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or c) a Covered Person's parents, whether natural, step or adoptive; or d) a Covered person's Sisters or Brothers, otherwise. 4. The estate of the Covered Person. A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt. A Dependent's beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Covered Person's estate.
Right of Reimbursement	RIGHT OF REIMBURSEMENT: If a Covered Person incurs expenses for Injury that occurred due to the negligence of a third party: 1. We have the right to reimbursement for all benefits We paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, Covered Person's parents, if the Covered Person is a minor, or Covered Person's legal representative as a result of that Injury: and 2. We are assigned the right of recover from the third party, or his or her insurer, to the extent of the benefits We paid for that Injury. We shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to obtain for the same expenses We have paid as a result of that Injury. The Covered Person is required to furnish any information or assistance or provide any documents that We may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.
INDIANA	
EFFECTIVE DATES OF INSURANCE	
Newborn Child Exception	Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are insured as a Dependent under the Policy and this Certificate. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse. Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the earlier of the date of placement in the Insured Person's home or on the date of an order granting the adoptive parents custody. A notice of placement for adoption must be submitted to Us. If notice is not given within 31, days, coverage for the adopted Child will terminate. Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child.
CLAIMS PROVISIONS	
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss. We shall pay or deny each Clean Claim as follows: (1) if the claim is filed electronically, within 30 days after the date We receive the claim; or (2) if the claim is filed on paper, within 45 days after the date We receive the claim. We shall notify a claimant of any deficiencies in a submitted claim not more than: (1) 30 days for a claim that is filed electronically; or (2) 45 days for a claim that is filed on paper; and describe any remedy necessary to establish a Clean Claim. Our failure to notify a claimant as required above establishes the submitted claim as a Clean Claim. If We fail to pay or deny a Clean Claim in the time required above, and We subsequently pay the claim, We shall pay the claimant interest, at the rate prescribed by Indiana law, on the allowable amount of the claim paid. Interest accrues beginning: (1) 31 days after the date the electronic claim is filed; or (2) 46 days after the date the paper claim is filed; and stops on the date the claim is paid. A "Clean Claim" means a claim submitted for payment that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

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PROVISION[2]	PROVISION DESCRIPTION[2]
INDIANA	
SCOPE OF COVERAGE	
Facility of Payment	Facility of Payment Another plan may pay a Benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. Any amount so paid will be considered a Benefit under this plan. We will not be liable for such payment after it is made. Whenever used in this provision:
IOWA	
PREMIUM PROVISIONS	
Changes in Premium Rate	Changes in Premium Rate The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy and this Certificate. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
KANSAS	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN KS**.
EFFECTIVE DATES OF INSURANCE	
Covered Person's Effective Date	Covered Person's Effective Date: A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of: 1. The Effective Date of the Policy; or 2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form Newborn Children Coverage: We will pay benefits for a newborn Child from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate Newborn Adopted Children Coverage: A newborn Child adopted by You shall be covered for the first 31 days from birth provided that the petition for adoption is filed within those initial 31 days.
CLAIMS PROVISIONS	
Legal Actions	LEGAL ACTIONS: All Policy terms will be interpreted under the laws of the state in which the Policy and this Certificate was issued. No legal action may be brought to recover on the Policy and this Certificate within 60 days after written Proof of Loss has been furnished. No legal action may be brought after five (5) years from the time written Proof of Loss is required to be furnished.
Errors Related To Your Coverage	ERRORS RELATED TO YOUR COVERAGE: We have the right to correct benefit payments that are made in error. Providers and/or You have the responsibility to return any overpayments to Us. We have the responsibility to make additional payments if any underpayments have been made.

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PROVISION[2]	PROVISION DESCRIPTION[2]
KENTUCKY	
TERMINATION OF INSURANCE	
Dependent's Termination Date	Dependent's Termination Date A Dependent's coverage under the Policy and this Certificate ends on the earliest of: 1. The date the Policy terminates; or 2. The date the Covered Person's coverage ends; or 3. The date the Dependent is no longer a Dependent; or 4. The last day of the period for which premiums have been paid subject to the grace period provision.
LOUISIANA	
PREMIUM PROVISIONS	
Changes in Premium Rate	Changes in Premium Rate We may change the premium rates with at least 31 days advanced written notice. However, We shall notify the Policyholder in writing at least forty-five days before any increase of twenty percent or more in the premium rates. We shall not increase the premium rates during the initial twelve months of coverage and not more than once in any six-month period following the initial twelve-month period. This does not apply to increases in the premium amount due to the addition of a new Covered Person or a change in age or geographic location of an individual Covered Person or Policyholder or an increase in the Policy benefit level. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
CLAIMS PROVISIONS	
Notice of Claim	NOTICE OF CLAIM: Written notice of death or injury must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given at Our administrative office as shown on the cover page or to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Covered Person's name and address. Such notice given by or on behalf of the Covered Person or the beneficiary to US, or to any authorized agent of Ours, with information sufficient to identify the Covered Person, shall be deemed notice to Us. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1. it can be shown that it was not possible within reason to submit notice within the 30 day period; and 2. it is further shown that notice was given as soon as reasonably possible.
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: All claims arising under the terms of the Policy shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the Policy, are furnished to Us unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. We shall make payment at least every thirty days to the Covered Person during that part of the period of His disability covered by the Policy during which He is entitled to such payments. Failure to comply with this provision shall subject Us to a penalty payable to the Covered Person of double the amount of the benefits due under the terms of the Policy during the period of delay, together with attorney's fees to be determined by the court.
Subrogation	SUBROGATION: If We have paid benefits to a Covered Person for Injuries received in a covered Accident, and in Our opinion a third party may be liable, We will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents. Any right of recovery We have from any third parties is secondary to the Covered Person's right to be fully compensated for damages. In addition, We will share in any legal expenses incurred.

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PROVISION[2]	PROVISION DESCRIPTION[2]
LOUISIANA	
GENERAL PROVISIONS	
Entire Contract Changes	ENTIRE CONTRACT; CHANGES: The Policy, this Certificate, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at Our option, may also be made a part of this contract. All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 3-years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested. No change in the Policy or this Certificate will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy and this Certificate. No agent may change the Policy or this Certificate or waive any of its provisions.
MICHIGAN	
CLAIMS PROVISIONS	
Conditional Claim Payment	The Conditional Claim Payment provision is amended in Amendatory Rider to read as follows: CONDITIONAL CLAIM PAYMENT: If a Covered Person incurs expenses for Injuries received in a covered Accident, and a third party is liable, We will pay benefits if: 1. The Covered Person first agrees in writing to refund the lesser of: (a) The amount We actually paid for such expenses; or (b) The amount actually received from the third party for such expenses; and 2. The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, prior to Our payment of benefits under this Policy, if the third party's liability is satisfied in an amount less than the benefits payable under this Policy, We will pay the difference.
Subrogation	The Subrogation Provision is amended in the Amendatory Rider as follows: SUBROGATION: If We have paid benefits to a Covered Person for Injuries received in a covered Accident, and a third party is liable, We will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents.
MISSISSIPPI	
CLAIMS PROVISIONS	
Payment of Claims	PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Certificate. All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Certificate.

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PROVISION[2]	PROVISION DESCRIPTION[2]
MISSISSIPPI	
CLAIMS PROVISIONS	
Time of Payment of Claims	The Time of Payment of Claims provision is amended to read as follows: TIME OF PAYMENT OF CLAIMS: Benefits due under this Policy for any loss, other than a loss for which this Policy provides installments, will be paid immediately or within twenty-five (25) days upon receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid immediately or within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. If clean claims are not paid within the above time frame it will be considered overdue. A " clean claim " means a claim received by Us for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the Covered Person in order to be processed and paid by Us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. A clean claim does not include any of the following: a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim; b. Claims which are submitted fraudulently or that are based upon material misrepresentations; c. Claims that require information essential for Us to administer preexisting condition, coordination of benefits or subrogation provisions; or d. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the Covered Person, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.
MISSOURI	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN MO**.
EFFECTIVE DATES OF INSURANCE	
Covered Person's Effective Date	Covered Person's Effective Date: A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of: (1) The Effective Date of the Policy; or (2) The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form Newborn Children Coverage: We will provide coverage for a newborn Child from the moment of birth. The Insured Person must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate at the expiration of the initial 31 day period. If an application or other form of enrollment is required in order to continue coverage beyond the 31 day period after the date of birth and the Insured Person has notified Us of the birth, either orally or in writing, We shall, upon notification, provide the Insured Person with all forms and instructions necessary to enroll the newly born child and shall allow the Insured Person an additional 10 days from the date the forms and instructions are provided in which to enroll the newly born child. Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by the Insured Person prior to the birth of the Child, whether or not such agreement is enforceable. The Insured Person must give Us notice within 31 days of the birth of the adopted Child. If notice is not given within 31 days, coverage for the newborn adopted Child will terminate at the expiration of the initial 31 day period. If an application or other form of enrollment is required in order to continue coverage beyond the 31 day period after the date of birth and the Insured Person has notified Us of the birth, either orally or in writing, We shall, upon notification, provide the Insured Person with all forms and instructions necessary to enroll the newly born child and shall allow the Insured Person an additional 10 days from the date the forms and instructions are provided in which to enroll the newly born child.
Newborn Child Exception	Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are insured as a Dependent under the Policy and this Certificate. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse. Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in the Insured Person's home. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate at the expiration of the initial 31 day period. Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child.

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PROVISION[2]	PROVISION DESCRIPTION[2]
MISSOURI	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN MO**.
TERMINATION DATE OF INSURANCE	
Extension of Benefits	Extension of Benefits If a Covered Person is totally disabled when the coverage terminates, We shall continue to pay covered benefits, in accordance with the Policy in effect at the time the Covered Person's coverage terminates, for expenses incurred by the Covered Person for the condition causing the disability until the earlier of: (a) the date the Covered Person ceases to be totally disabled; or (b) 12 months after the date coverage terminates. The Covered Person must provide the Company proof that He or She is Totally Disabled.
PREMIUM PROVISIONS	
Changes in Premium Rate	Changes in Premium Rate The Company may change the premium rates from time to time with at least 31 advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy and this Certificate. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. 6) A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
Newly Acquired Subsidiaries	NEWLY ACQUIRED SUBSIDIARIES: The premium for the Policy and this Certificate applies to the risks assumed on the Effective Date of the Policy and this Certificate. Eligible employees or members of subsidiaries newly acquired through merger, stock purchase, exchange of stock, or otherwise, shall be insured under the Policy and this Certificate, subject to the following conditions: 1. The Policyholder has at least 50% controlling interest in the subsidiary. 2. An additional premium payment is required with a report to us and the name of any newly acquired subsidiary. 3. Necessary underwriting information must be furnished for us to determine the additional risks assumed. 4. Coverage will begin on the legal date of acquisition. No coverage shall continue for more than 60 days after the legal acquisition date unless the required report with the necessary data is supplied and the additional premium paid. The Policyholder shall be liable for payment of premium for the period during which such coverage remains in effect.
CLAIMS PROVISIONS	
Payment of Claims	PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Certificate. If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment. Any other accrued benefits which are unpaid at a Covered Person's death may, at Our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person. All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Certificate. Benefits payable to the Covered Person shall be paid, with or without an assignment from the Covered Person, to public hospitals or clinics for services and supplies provided to the Covered Person if a proper claim is submitted by the public hospital or clinic. No benefits shall be paid to the public hospital or clinic if such benefits have been paid to the Covered Person prior to receipt of the claim by Us. Payment to the public hospital or clinic of benefits shall discharge Us from all liability to the Covered Person to the extent of the benefits paid. Nothing shall be construed to require payment of benefits for the same services or supplies to both the Covered Person and the public hospital or clinic.

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PROVISION[2]	PROVISION DESCRIPTION[2]
MISSOURI	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN MO**.
CLAIMS PROVISIONS	
Recovery of Overpayment	RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error, no later than 12 months from the date We have paid the claim, any of the following methods. 1) A request for lump sum payment of the amount overpaid or paid in error or 2) Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.
NEBRASKA	
EFFECTIVE DATES OF INSURANCE	
Covered Person's Effective Date	Covered Person's Effective Date: A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of: 1. The Effective Date of the Policy; or 2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form Newborn Children Coverage: We will pay benefits for a newborn Child from the moment of birth. You must give Us notice of the birth within 31 days of the birth of the Child in order for coverage to continue beyond the first 31 days. If notice is not given within 31 days, coverage for the newborn Child will terminate. Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by You prior to the birth of the Child, whether or not such agreement is enforceable.
CLAIMS PROVISIONS	
Conditional Claim Payment	CONDITIONAL CLAIM PAYMENT: If a Covered Person incurs expenses for Injuries received in a covered Accident, and in Our opinion a third party may be liable, We will pay benefits if: 1. The Covered Person first agrees in writing to refund the lesser of: (a) The amount We actually paid for such expenses; or (b) The amount actually received from the third party for such expenses; and 2. The third party's liability is determined and satisfied whether by settlement, judgment or otherwise. However, prior to Our payment of benefits under this Certificate, if the third party's liability is satisfied in an amount less than the benefits payable under this Certificate, We will pay the difference.
Recovery of Overpayment	RECOVERY OF OVERPAYMENT If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods. 1. A request for lump sum payment of the amount overpaid or paid in error or 2. Reduction of any proceeds payable under this Certificate by the amount overpaid or paid in error. Such recovery of overpayment will be made within three years of the date of the error. We will not withhold any portion of any benefit payable, on the basis that the sum withheld is an adjustment or correction of an overpayment made on a prior claim arising under the same Policy unless: 1. We have documented evidence of an overpayment or error and written authorization from the claimant permitting such withholding procedure, or 2. We have documented evidence that: a) The overpayment was clearly erroneous under the provisions of the Policy; and b) The error which resulted in the overpayment is not a mistake of law; and c) We provide written notice to the claimant within six (6) months of the date of the error. If the error was caused by misrepresentations or nondisclosures of the claimant, We will provide 15 days written notice describing the error, the amount of the overpayment, and the three year limitation for such recovery.
Subrogation	SUBROGATION: If We have paid benefits to a Covered Person for Injuries received in a covered Accident, and in Our opinion a third party may be liable, We will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents. The Covered Person will be fully compensated before We can subrogate against Him.

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PROVISION[2]	PROVISION DESCRIPTION[2]
NEBRASKA	
GENERAL PROVISIONS	
Conformity with State and Federal Law	CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of the Policy and this Certificate which, on its effective date, is in conflict with the law of the federal government or the State in which the insured resides on such date is hereby amended to conform to the minimum requirements of such laws.
NEW JERSEY	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN NJ**.
CLAIMS PROVISIONS	
Claim Forms	CLAIM FORMS: When We receive the notice of claim, We will send forms for filing proof of loss. If the person submitting the claim does not receive such claim forms within 15 days after We have received notice of claim, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.
Proof of Loss	PROOF OF LOSS: Written proof of loss must be furnished to Us in the case of a claim for loss for which this Certificate provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by us. In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss. If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1. it can be shown that it was not possible within reason to submit notice within the 90 day period; and 2. it is further shown that notice was given as soon as reasonably possible.
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Benefits due under this Policy for a loss, other than a loss for which this Policy provides installments, will be paid not more than 60 days after the Company receives proper written proof of such loss. Subject to written proof of loss, all accrued benefits for loss for which this Certificate provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits. Neither termination of this Policy nor termination of the Covered Person's coverage under the Policy shall prejudice the settlement of any claim for loss where the Accident precipitating the loss occurred on or before the date of termination.
GENERAL PROVISIONS	
Entire Contract Changes	ENTIRE CONTRACT; CHANGES: The Policy, this Certificate, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at Our option, may also be made a part of this contract. All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested. No change in the Policy or Certificate will be valid until approved by one of Our executive officers and evidenced by endorsement on the Policy and Certificate, or by amendment to the Policy and Certificate signed by the Policyholder and Us. No agent may change the Policy or this Certificate or waive any of its provisions.
Payment of Premiums	PAYMENT OF PREMIUMS: All premiums due under the Policy shall be remitted by the Policyholder to Us on or before the due date, subject to any applicable Grace Period provision.

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PROVISION[2]	PROVISION DESCRIPTION[2]
NEW MEXICO	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN NM**.
PREMIUM PROVISIONS	
Changes in Premium Rate	Changes in Premium Rate The Company may change the premium rates from time to time with at least 31 advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy and this Certificate. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
Newly Acquired Subsidiaries	NEWLY ACQUIRED SUBSIDIARIES: The premium for the Policy and this Certificate applies to the risks assumed on the Effective Date of the Policy and this Certificate. Eligible employees or members of subsidiaries newly acquired through merger, stock purchase, exchange of stock, or otherwise, shall be insured under the Policy and this Certificate, subject to the following conditions: 1. The Policyholder has at least 50% controlling interest in the subsidiary. 2. An additional premium payment is required with a report to us and the name of any newly acquired subsidiary. 3. Necessary underwriting information must be furnished for us to determine the additional risks assumed. 4. Coverage will begin on the legal date of acquisition. No coverage shall continue for more than 60 days after the legal acquisition date unless the required report with the necessary data is supplied and the additional premium paid. The Policyholder shall be liable for payment of premium for the period during which such coverage remains in effect.
NORTH CAROLINA	
EFFECTIVE DATES OF INSURANCE	
Covered Person's Effective Date	Covered Person's Effective Date: A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of: 1. The Effective Date of the Policy; or 2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form Newborn Children Coverage: We will pay benefits for a newborn Child from the moment of birth. Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by You prior to the birth of the Child, whether or not such agreement is enforceable. Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in the Covered Person's home. If additional monthly premiums will be required to enroll a new dependent child, the Covered Person must submit an Enrollment Application and Change Form through the group within 31 days of acquiring the new dependent. This applies to a newborn child or an adopted or foster child newly placed in the adoptive/foster home. If no additional monthly premium will be required when the Covered Person adds a dependent child to the plan, the Covered Person should complete a Status Change Form so that We may send an identification card to facilitate the child's access to covered services. A newborn child will be covered from the moment of birth. A foster care or adopted child will be covered from the date of placement in the home provided coverage for that child is put in to effect within 31 days.
Newborn Child Exception	Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are insured as a Dependent under the Policy and this Certificate. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse. Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child.

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PROVISION[2]	PROVISION DESCRIPTION[2]
NORTH CAROLINA	
TERMINATION DATE OF INSURANCE	
Policy Termination Date	Policy Termination Date Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination. The Policy terminates automatically on the earlier of: 1. The Policy Termination Date shown in this Policy; or 2. The premium due date if premiums are not paid when due subject to any grace period. Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid. The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 45 days prior to such date. The Policyholder and the Company may terminate this Policy at any time by written mutual consent. If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.
PREMIUM PROVISIONS	
Changes in Premium Rate	Changes in Premium Rate The Company may change the premium rates from time to time with at least 45 days advanced written or authorized electronic notice. Notice will be sent to the Policyholder's most recent address in Our records. An increase in rates will not be made more than once in a 12 month period. and will be based upon at least 12 months of experience. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting this Policy and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for this Policy. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
Reinstatement	Reinstatement If any renewal premium be not paid within the time granted for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate the Policy. The reinstated Policy shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such Injury as may begin more than 10 days after such date. In all other respects the Covered Person and Us shall have the same rights there under as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.
SCOPE OF COVERAGE	
"Plan" (under Facility Payment on the Coordination of Benefits / Scope of Coverage Section)	"Plan" means any plan which provides Benefits or services for, or by reason of, Hospital, surgical, medical, or dental care, or treatment through: 1. Service plan contracts, group or individual practice or other prepayment plans; 2. Coverage under any labor management trusteed Plans, union welfare plans, employer organization plans, professional organizations, self-funded plans or employee benefit organization plans which provides medical or dental benefits or services; or 3. Coverage under a governmental plan or required or provided by law, other than a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time); 4. Medicare (Title XVIII of the Social Security Act); and Plan does not include school accident-type coverage, blanket, franchise individual, automobile or homeowner coverage. Plan does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. Plan does not include coverage under individual or family policies or contracts. Each Plan or part of a Plan that has a right to coordinate benefits will be considered a separate Plan.

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PROVISION[2]	PROVISION DESCRIPTION[2]
NORTH CAROLINA	
CLAIMS PROVISIONS	
Proof of Loss	PROOF OF LOSS: Written proof of loss must be furnished to Us in the case of a claim for loss for which this Certificate provides periodic payment contingent upon continuing loss within 180 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by us. In case of claim for any other loss, proof must be furnished within 180 days after the date of such loss. If the proof of loss is not submitted within 180 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1. it can be shown that it was not possible within reason to submit notice within the 180 day period; and 2. it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
GENERAL PROVISIONS	
Entire Contract Changes	ENTIRE CONTRACT; CHANGES: The Policy, this Certificate, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at Our option, may also be made a part of this contract. All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Covered Person's effective date of coverage, no misstatements will cause such coverage to be void or cause the denial of a claim for loss incurred or disability commencing after the expiration of such two-year period. No change in the Policy or this Certificate will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy and this Certificate. No agent may change the Policy or this Certificate or waive any of its provisions.
Records Maintained	RECORDS MAINTAINED: The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person's insurance under the Policy and this Certificate for not less than five years. We shall be permitted to examine the Policyholder's records relating to coverage under this Certificate. Examination may occur at any reasonable time up to the later of: 1. The five year period after the expiration of the Policyholder's coverage; or 2. The final adjustment and settlement of all claims under the Policyholder's coverage.
Policy Termination	POLICY TERMINATION: We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 45 days prior to such premium due date.
NORTH DAKOTA	
PREMIUM PROVISIONS	
Changes in Premium Rate	Changes in Premium Rate The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy and this Certificate. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

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PROVISION[2]	PROVISION DESCRIPTION[2]
OHIO	
EFFECTIVE DATES OF INSURANCE	
Newborn Child Exception	Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to You while You are insured as a Dependent under the Policy and this Certificate. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse. Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in Your home. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate. Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child. There will be no enrollment restrictions placed on a Child in Court Ordered Custody and coverage will be effective immediately.
CLAIMS PROVISIONS	
Proof of Loss	PROOF OF LOSS: Written proof of loss must be furnished to Us in the case of a claim for loss for which this Certificate provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by us. In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss. If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1. it can be shown that it was not possible within reason to submit notice within the 90-180 day period; and 2. it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
GENERAL PROVISIONS	
Entire Contract Changes	ENTIRE CONTRACT; CHANGES: The Policy, this Certificate, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured will also be made a part of this contract. All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested. No change in the Policy or this Certificate will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy and this Certificate. No agent may change the Policy or this Certificate or waive any of its provisions.
OKLAHOMA	
CLAIMS PROVISIONS	
Recovery of Overpayment	The Recovery of Overpayment Provision is revised on the Amendatory Rider in Oklahoma to read: RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error within twenty-four (24) months from the time the overpayment was made by any of the following methods. 1. A request for lump sum payment of the amount overpaid or paid in error or 2. Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.

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PROVISION[2]	PROVISION DESCRIPTION[2]
VERMONT	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN VT**.
TERMINATION OF INSURANCE	
Extension of Benefits	Extension of Benefits In the event of total disability of the Covered Person on the date of termination of the Policy, benefits will be extended 90 days. The benefits payable during such a period of extension will be subject to the regular benefit limits
PREMIUM PROVISIONS	
Changes in Premium Rate	Changes in Premium Rate The Company may change the premium rates from time to time with at least 45 days advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy and this Certificate. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
CLAIMS PROVISIONS	
Proof of Loss	PROOF OF LOSS: Written proof of loss must be furnished to Us in the case of a claim for loss for which this Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by us. In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss. If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1. it can be shown that it was not possible within reason to submit notice within the 90 day period; and 2. it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required, or as soon as reasonably possible thereafter.
Payment of Claims	PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Certificate. All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Certificate . If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment. Any other accrued benefits which are unpaid at a Covered Person's death may, at Our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person. Amounts payable under this Policy will be paid within 30 days upon receipt and acceptance by the Company of Proof of Loss.

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PROVISION[2]	PROVISION DESCRIPTION[2]
VERMONT	THIS IS ONLY TO TALK TO CURRENT CUSTOMERS WHEN EXPLAINING COVERAGE - **NO NEW SALES IN VT**.
CLAIMS PROVISIONS	
Designation or Change of Beneficiary	DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order: 1. Beneficiaries designated in writing by the Covered Person for this Certificate on file with the Policyholder, if any, otherwise; 2. Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise; 3. In equal shares to the members of the first surviving class of those that follow, if any: a) a Covered Person's lawful spouse, including civil union partner, if not legally separated or divorced, or Domestic Partner; b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or c) a Covered Person's parents, whether natural, step or adoptive; or d) a Covered person's Sisters or Brothers, otherwise. 4. The estate of the Covered Person. A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt. A Dependent's beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Covered Person's estate.
Legal Actions	LEGAL ACTIONS: All Policy terms will be interpreted under the laws of the state of Vermont. No legal action may be brought to recover on the Policy and this Certificate within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.
GENERAL PROVISIONS	
Conformity with Vermont Statutes	CONFORMITY WITH VERMONT STATUTES: Any provision of the Policy in conflict on its effective date with the laws of the State of Vermont is amended to conform to the minimum requirements of such laws.
Independent Review	INDEPENDENT REVIEW: If a Covered Person has exhausted all applicable internal review procedures they shall have the right to an independent external review of a decision made by Us to deny, reduce or terminate coverage or to deny payment for a service. The independent review will be available when requested in writing by the Covered Person, provided the decision to be reviewed requires Us to expend at least $100.00 for the service and the decision by Us is based on one of the following reasons: 1. The service is a covered benefit that We have determined to be not medically necessary; 2. A limitation is placed on the selection of a health care provider that is claimed by the insured to be inconsistent with limits imposed by Us and any applicable laws and rules; 3. The treatment has been determined to be experimental, investigational or an off-label drug; or 4. We make a medically-based decision that a condition is preexisting. The right to review under this section shall not be construed to change the terms of coverage under this Policy. Health care services provided to inmates by the department of corrections.

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PROVISION[2]	PROVISION DESCRIPTION[2]
VIRGINIA	
TERMINATION OF INSURANCE	
Policy Termination Date	Policy Termination Date Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination. The Policy terminates automatically on the earlier of: 1. The Policy Termination Date shown in the Policy; or 2. The premium due date if premiums are not paid when due subject to any grace period. Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid subject to the grace period provision. The Policy may be terminated by the Policyholder or the Company as of any premium due date subject to the grace period or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date. The Policyholder and the Company may terminate the Policy at any time by written mutual consent. If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.
Covered Person's Termination Date	Covered Person's Termination Date Insurance for a Covered Person will end on the earliest of: 1. The date He is no longer in an Eligible Class. 2. The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of: (a) The date the premium is fully earned; or (b) The Expiration Date of this Policy. This does not include Reserve or National Guard duty for training; 3. The end of the period for which the last premium contribution is made subject to the grace period; or 4. The date this Policy is terminated; or 5. The date the Covered Person requests, in writing, that his/her coverage be terminated.
Dependent's Termination Date	Dependent's Termination Date A Dependent's coverage under the Policy ends on the earliest of: 1. The date the Policy terminates; or 2. The date the Covered Person's coverage ends; or 3. The date the Dependent is no longer a Dependent; or 4. The last day of the period for which premiums have been paid subject to the grace period.
PREMIUM PROVISIONS	
Premiums	PREMIUMS: The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of this Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid, subject to the Grace Period. The Company has the right to rely upon the accuracy of the Policyholder's calculations and to require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.
Grace Period	GRACE PERIOD: A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under this Policy. Coverage will end if the premium is not paid by the end of the grace period.

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PROVISION[2]	PROVISION DESCRIPTION[2]
VIRGINIA	
PREMIUM PROVISIONS	
Changes in Premium Rate	Changes in Premium Rate The Company may change the premium rates from time to time with at least 31days advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur: 1. A change in the terms of the Policy and this Certificate. 2. A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy. 3. A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation. 4. A change in the factors bearing on the risk assumed. 5. A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate 6. A change in the experience rating. If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.
SCOPE OF COVERAGE	
"Plan" (under Facility Payment on the Coordination of Benefits / Scope of Coverage Section)	"Plan" means any plan which provides Benefits or services for, or by reason of, Hospital, surgical, medical, or dental care, or treatment through: 1. Group or blanket insurance coverage; 2. Service plan contracts, group or individual practice or other prepayment plans; 3. Coverage under any labor management trusteed Plans, union welfare plans, employer organization plans, professional organizations, self-funded plans or employee benefit organization plans which provides medical or dental benefits or services; or 4. A government program, or statue, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965; and 5. Medicare (Title XVIII of the Social Security Act.. Plan does not include coverage under individual or family policies or contracts. Each Plan or part of a Plan that has a right to coordinate benefits will be considered a separate Plan.
CLAIMS PROVISIONS	
Claim Forms	CLAIM FORMS: When We receive the notice of claim, We will furnish forms for filing proof of loss. If claim forms are not furnished within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.
Proof of Loss	PROOF OF LOSS: Written proof of loss must be furnished to Us in the case of a claim for loss for which this Certificate provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by us. Proof of continued Total Disability must be certified by a Physician. Subsequent written proof of the continuance of the Disability will be required no less frequently than monthly but no more than on a quarterly basis, based upon the clinical information provided by the Physician. In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss. If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1. it can be shown that it was not possible within reason to submit notice within the 90 day period; and 2. it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

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PROVISION[2]	PROVISION DESCRIPTION[2]
VIRGINIA	
CLAIMS PROVISIONS	
Claims Experience	CLAIMS EXPERIENCE Upon request, We will provide the Policyholder with a complete record of the Policyholder's medical claims experience or medical costs incurred under the Policy. This record shall include all claims incurred for the lesser of (i) the period of time since the Policy was issued or issued for delivery or (ii) the period of time since the Policy plan was last renewed, reissued or extended, if already issued. The record shall be made available promptly to the Policyholder upon request that is made not less than 30 days prior to the date upon which premiums or terms of the Policy may be amended. This information will not include the disclosure of personal or privileged information about an individual Covered Person that is protected from disclosure under any federal or state law or regulation. The Policyholder will not be required to pay for information requested.
GENERAL PROVISIONS	
Entire Contract Changes	ENTIRE CONTRACT; CHANGES: This Policy, this certificate, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured will also be made a part of this contract. All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or his beneficiary or personal representative. After 2-years from the Covered Person's effective date of coverage, no such statement will cause such coverage to be contested. No change in the Policy or this Certificate will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy and this Certificate. No agent may change this Policy or waive any of its provisions.

Other State Variations:

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Coordination of Benefits - MISSOURI:

UNDER SCOPE OF COVERAGE

Below are MO Coordination of Benefits Provision for explaining to current customers only. This is not for new sales.

Coordination of Benefits Provision:

If a Covered Person is insured for Benefits under this Policy, and is also covered for these Benefits under one or more other Plans, the benefits payable under this Policy will be coordinated with the benefits payable under all other Plans.

I. **APPLICABILITY**

A. This coordination of benefits (COB) provision applies to this coverage when a Covered Person has health care coverage under more than one (1) plan. Plan and this plan are defined here.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan —

1. Shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but
2. May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is described in Section IV. Effect on the Benefits of This Plan.

II. **DEFINITIONS**

A. **Plan** is any of these which provide benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is a separate plan.

B. **This plan** is the part of the group contract that provides benefits for health care expenses.

C. **Primary plan/secondary plan**. The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two (2) plans covering the person. This plan may be a primary plan as to one (1) or more other plans and may be a secondary plan as to a different plan(s).

D. **Allowable expense** means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one (1) or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of that reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or similar provision takes effect.

Coordination of Benefits - MISSOURI:

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III. **ORDER OF BENEFIT DETERMINATION RULES**

A. **General**. When there is a basis for a claim under this plan and another plan. This plan is a secondary plan which has its benefits determined after those of the other plan, unless —

1. The other plan has rules coordinating its benefits with those of this plan; and
2. Both those rules and this plan's rules, in subsection III.B., require that this plan's benefits be determined before those of the other plan.

B. **Rules**. This plan determines its order of benefits using the first of the following rules which applies:

1. Nondependent/dependent. The benefits of the plan which covers the person as a member (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that — if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is —

   (a) Secondary to the plan covering the person as a dependent; and

   (b) Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

2. **Dependent child/parents not separated or divorced**. Except as stated in paragraph III.B(3), when this plan and another plan cover the same child as a dependent of different persons, called parents —

   (a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

   (b) If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described previously in III.B.(2)(a) or (b) and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. **Dependent child/separated or divorced**. If two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   (a) First, the plan of the parent with custody of the child;

   (b) Then, the plan of the spouse of the parent with the custody of the child; and

   (c) Finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first.

   The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Joint custody**. If the specific terms of a court degree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph III.B.(2).

5. **Active/inactive employee**. The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.

6. **Continuation coverage**. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

   (a) First, the benefits of a plan covering the person as a member (or as that person's dependent); and

   (b) Second, the benefits under the continuation coverage. If the other plan does not have the rule described here and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. **Longer/shorter length of coverage**. If none of the previous rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

Coordination of Benefits - MISSOURI:

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IV. **EFFECT ON THE BENEFITS OF THIS PLAN**

A. **When This Section Applies**. This section IV. applies when, in accordance with section III., Order of Benefit Determination Rules, this plan is a secondary plan as to one (1) or more other plans. In that event the benefits of this plan may be reduced under this section. Other plan(s) are referred to as the other plans in IV.B. Immediately following.

B. **Reduction in this plan's benefits**. The benefits of this plan will be reduced when the sum of:

(1) The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and

(2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. When the benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

V. **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts are needed to apply these COB rules. (Insurer) has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. (Insurer) need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give (insurer) any facts it needs to pay the claim.

VI. **FACILITY OF PAYMENT**

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, (insurer) may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under this plan. (Insurer) will not have to pay that amount again. The term, payment made includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

VII. **RIGHT OF RECOVERY**

If the amount of the payments made by (insurer) is more than it should have paid under this COB provision, it may recover the excess from one (1) or more of —

A. The person it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations. The amount of the payments made includes the reasonable cash value of any benefits provided in the form services.

Grievance Procedures - WYOMING:

The following Grievance Procedures are added to the General Provisions of the Certificate in Wyoming:

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance.

These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A "**Grievance**" is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An "**Adverse Determination**" is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 30-days after the date You receive a denial of claim. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem. If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information. If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted within 30 days by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf. If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide You, Your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review.

The Insured may, however, submit written material for consideration by the reviewer(s).

Grievance

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter. Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

1. The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
2. A statement of the reviewer's understanding of the Grievance.
3. The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
4. A reference to the evidence or documentation used as the basis for the decision.
5. If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
6. A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and time frames for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination and request additional review within 30 days. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

1. the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
2. a statement of your rights, including the right to:
   - attend the Second Level Review
   - present his/her case to the review panel;
   - submit supporting materials before and at the review meeting;
   - ask questions of any member of the review panel;
   - be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
   - request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel, hold a review meeting, and issue a decision within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

1. were not previously involved in any matter giving rise to the Second Level Review;
2. are not employees of the Company or Utilization Review Organization; and
3. do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

Grievance

We must issue a written decision to you and, if applicable, to your representative or provider, within 45 days after receiving your request for Second Level Review. The decision must include:

1. the name(s), title(s) and qualifying credentials of the members of the review panel;
2. a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
3. the review panel's recommendation to the Company and the rationale behind the recommendation;
4. a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
5. in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
6. the rationale for the Company's decision if it differs from the review panel's recommendation;
7. a statement that the decision is the Company's final determination in the matter;
8. notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

You may file a request for External Review of your claim if:
(1) you have filed an appeal involving a denied claim; or
(2) except to the extent you or your authorized representative requested or agreed to a delay, has not received a written decision on the grievance from us within thirty (30) days following the date you or your authorized representative filed the grievance with us.

This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Group Accident Insurance underwritten by United States Fire Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Please review for full details. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

Grievance Procedures - WYOMING:

EXTERNAL REVIEW

Within sixty (60) days of receiving the written Second Level Review decision, you may request an external review of the decision which is the subject of the explanation by filing a written request for such review. The request must be submitted to us on a form approved by the commissioner, unless such form was not provided to you, in which event any written request for an external review will be sufficient. The request must include a health professional certification of medical necessity.

Upon receiving a request for external review, we will:

1. Within 5 business days of receiving the request, send a copy of the request to the commissioner with the filing fee;
2. Assign the request to an independent review organization that has been approved by the commissioner for a preliminary review. We will provide to the independent review organization all documents and information upon which we relied in denying all claims under review. Failure to provide the documents and other information will not delay the conduct of the external review. The independent review organization will determine whether:
   - You are or were a covered person in the Policy at the time the provision of or payment for medical services, procedures or supplies was requested or provided;
   - The provision of or payment for medical services, procedures or supplies requested by you reasonably appears to be a covered service under the Policy, but for our determination that the services, procedures or supplies are not a medical necessity;
   - We have denied your request for the provision of or payment for medical services, procedures or supplies after having been given the opportunity to review our first denial one (1) or more times;
   - You have provided to us all the information and forms required to process an external review, including a release form, approved by the commissioner, by which you authorize the release of protected health information pertinent to the external review.

The independent review organization shall within five (5) days determine whether the documentation is complete and immediately notify you and us in writing whether the documentation is complete and, if not, what information or documentation is missing. You may submit in writing to the independent review organization any additional supporting documentation that the independent review organization should consider or may require when conducting its external review. If the request for review is not complete, the independent review organization shall require from us or you the information or materials needed to make the request complete. All documentation or other information provided to the independent review organization by us or you shall also be immediately provided to the adverse party by the independent review organization. We may use any documentation or other information provided by you to reconsider our settlement of the claims. If we choose to reverse our prior decision, we shall immediately provide written notice to you, the independent review organization and the commissioner, at which time the review shall be terminated.

In addition to the documents and information provided, the independent review organization, to the extent the information is available and the independent review organization considers them appropriate, shall consider the following in reaching its decision:

1. Your medical records;
2. The attending health care professional's recommendation;
3. Consulting reports from appropriate health care professionals and other documents submitted by us, you or your treating provider;
4. The terms of coverage under your Policy;
5. The standards for Medical Necessity;
6. All evidence based research used in our denial of the claim.

Within forty-five (45) days after the date of receipt of the request for external review, the assigned independent review organization shall provide written notice to you, us and the commissioner of its decision to uphold or reverse our decision that the provision of or payment for medical services, procedures or supplies requested by you are not medically necessary. Such written notice shall include:

1. A general description of the reason for the request for external review;
2. The date the independent review organization received the assignment from us to conduct the review;
3. The date the external review was conducted;
4. The date of its decision;
5. The principal reasons for its decision;
6. The rationale for its decision; and
7. References to the evidence or documentation considered in reaching its decision.

In the event the external review organization determines the claims should be allowed, we shall approve the request for the provision of or payment for medical services, procedures or supplies that was the subject of the review and notify you of such approval within five (5) days.

The engagement by us of an independent review organization to conduct an external review shall be fair and impartial. We, You and the independent review organization shall comply with regulations promulgated by the commissioner to ensure fairness and impartiality in the engagement of approved independent review organizations, in the terms, termination and payment of independent review organizations and in the review process.

EXPEDITED REVIEW

You are eligible for an expedited review when the time frames for an Informal, formal First Level review, Second Level review or External Review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews. If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

INSURANCE PREMIUMS FOR GROUP ACCIDENT INSURANCE

UNDERWRITTEN BY UNITED STATES FIRE INSURANCE COMPANY

GAP PLUS LEGACY	Insurance Premiums† (per month)
Individual	$4.93
Individual+1	$9.88
Family	$17.27

GAP PLUS 7350	Insurance Premiums† (per month)
Individual	$5.42
Individual+1	$10.87
Family	$19.00

GAP PLUS, GAP, & GAP+	Insurance Premiums† (per month)
Individual	$5.42
Individual+1	$10.87
Family	$19.00

†This is only the Group Accident Insurance Premiums for these plans. There could be **other insurance premiums** for different types of group insurance and/or **non-insurance Benefit Boost subscriptions costs** included in the total overall plan cost on the enrollment application. The member must join the United Business Association to enroll in any of the Group Accident Insurance plans offered on the UBA Enrollment. UBA dues are **in addition** to the overall member plan cost and are **$10 per month** for the entire family.

NOTE: THIS IS NOT THE PLAN COST OF THE PLAN.
IT IS JUST THE INSURANCE PREMIUMS FOR THE GROUP ACCIDENT INSURANCE.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

INSURANCE PREMIUMS FOR GROUP ACCIDENT INSURANCE

UNDERWRITTEN BY UNITED STATES FIRE INSURANCE COMPANY

GAP AME+ER, GAP MAX, GAP MAX+	Insurance Premiums† (per month)
Individual	$5.42
Individual+1	$10.87
Family	$19.00

SUPER GAP	Insurance Premiums† (per month)
Individual	$5.42
Individual+1	$10.87
Family	$19.00

SUPER GAP PLUS & SUPER GAP+	Insurance Premiums† (per month)
Individual	$5.42
Individual+1	$10.87
Family	$19.00

†This is only the Group Accident Insurance Premiums for these plans. There could be **other insurance premiums** for different types of group insurance and/or **non-insurance Benefit Boost subscriptions costs** included in the total overall plan cost on the enrollment application. The member must join the United Business Association to enroll in any of the Group Accident Insurance plans offered on the UBA Enrollment. UBA dues are **in addition** to the overall member plan cost and are **$10 per month** for the entire family.

NOTE: THIS IS NOT THE PLAN COST OF THE PLAN.
IT IS JUST THE INSURANCE PREMIUMS FOR THE GROUP ACCIDENT INSURANCE.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

DISCLAIMERS FOR GROUP ACCIDENT INSURANCE

Below are the disclaimers that need to be disclosed to a potential member when doing a Group Accident Insurance sale that is underwritten by United States Fire Insurance Company.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

MAIN DISCLAIMER

This is a brief description of various group association insurance products and is not an insurance contract, nor part of the Certificate of Insurance and is subject to the terms, conditions, limitations, and exclusions of the Group Policy and Certificate(s) of Insurance. Coverage may vary or may not be available in all states. You'll find complete coverage details in the Certificate(s) of Insurance. Group Accident Insurance is underwritten by United States Fire Insurance Company, Eatontown, NJ. The insurance described in this document provides limited benefits. Limited benefit plans are insurance products with reduced benefits intended to help supplement comprehensive health insurance plans. The insurance coverage is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, the insurance coverage is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

Optional Supplemental UBA Gap Disclaimer

The optional supplemental UBA Gap plans available to members to add to their membership in the United Business Association allows the member to enhance their overall membership opportunities. These optional supplemental UBA Gap plans are not intended to supplement, not replace, comprehensive health insurance coverage. UBA Gap plans are not major medical insurance and should not be purchased to replace any major medical insurance, Cobra, Medicare, Medicaid, or Medical Disability coverage that you have in place currently. UBA Gap plans do not satisfy the requirement of minimum essential coverage under the Affordable Care Act and does not qualify or generate a 1095-A tax form.

Group Accident Insurance Disclaimer

You hereby request Group Accident Insurance that includes Accidental Death & Dismemberment and Accident Medical Expense benefits, underwritten by United States Fire Insurance Company, Eatontown, NJ.

You understand the insurance described provides limited benefits and that this insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act. You understand that the information contained herein is a summary of the coverage offered a Certificate of Insurance along with your membership guide will be made available to you upon enrollment. You will receive a UBA Gap I.D. card in the mail along with a welcome letter that includes your effective date for your membership plan.

You attest that you have read and understood the limitations and exclusions of this coverage:

(You should have emailed them a copy of the Certificate of Insurance for the state in which they reside to review prior to the sale being completed. It is best practices to keep a copy of the email which included a copy of the state-specific Certificate of Insurance that you sent the potential member for your records during the sales process in case of future complaint. It will help prove that you gave the member the information up front and that the member understood what they are purchasing.)

DISCLAIMERS FOR GROUP ACCIDENT INSURANCE

Below are the disclaimers that need to be disclosed to a potential member when doing a Group Accident Insurance sale that is underwritten by United States Fire Insurance Company.

(Any reference to CA, ID, KS, MO, NJ, NM, PA, or VT are for current member explanation ONLY and not for new sales.)

PAYMENT AUTHORIZATION

You authorize H A Partners, Inc. to initiate charges to your credit card in the total monthly amount shown for the plans or products you've selected. This authorization will remain in effect until H A Partners, Inc. receives notice from you that it should be cancelled.

UBA Membership and all optional supplemental UBA products are subscription based enrollments. You will continue to be drafted every month until you cancel by submitting a cancellation request via online form or email, or by phone at 866-438-4274.

Your total initial payment, which includes your first monthly payment for these selected products as well as any applicable administrative fees or one-time enrollments fees, will be charged immediately when your application is processed. Subsequent monthly payments will be charged on the 5th each month if your effective date is the 1st, or the 15th each month if your effective date is the 15th. If other UBA products have been purchased along with UBA membership, you will be charged only one monthly payment for the total cost of all purchased products. Your credit card statements will show these transactions as paid to "UBA GAP 866-438-4274".

You agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, it may result in forfeiture of your membership, and neither H A Partners, Inc. nor your financial institution shall be held liable whatsoever.

You agree that it is your responsibility to check the transactions occurring on your account every month and to cancel with us when desired. Every month we pay for the membership services and the insurance premiums for any applicable group insurance programs on your behalf, whether or not you use the membership services or file a claim with the group insurance programs (if applicable). Please refer to our Refund Policy for details on refunds.

You will receive your I.D. Cards in the mail within 14 days of purchase. Digital copies of your I.D. Cards, as well as all Membership Guides and Certificates of Insurance pertaining to the plans or products you've purchased, will be immediately available for download upon completion of your application. Please take the time to review all Guides and Certificates to ensure you fully understand your products and plan benefits, including any limitations, exclusions, definitions, or state variations.

You understand that the UBA membership, any optional supplemental UBA products you selected for this enrollment application are separate from any other health plans or insurance coverage you may have purchased or applied for elsewhere.

SATISFACTION GUARANTEED

We want you to be completely satisfied. If you have any problems, or any questions about your UBA Membership or any product benefits, please call your Personal Membership Concierge at 1-866-438-4274.

If you are not completely satisfied with your UBA Membership, any supplemental UBA Gap or Benefit Boost products, you can cancel at any time in the first thirty (30) days for a full refund of paid premiums or membership dues. Cancellation requests can be made by email (info@ubamembers.com), phone (866-438-4274), or through the Member Portal (members.UBAapplication.com). Any refunds are processed within 7-10 business days from date of request. **Please be aware that premiums & dues cannot be refunded if a claim has been filed for a group insurance benefit**. We showcase our name UBA GAP and our number 866-438-4274 on all transactions (all together like this UBAGAP8664384274) on your account statement, and it is your responsibility to check the transactions occurring on your account every month and to cancel with us when desired. Every month we pay for the membership services and the insurance premiums for any applicable optional supplemental group insurance programs on your behalf, whether you use the membership services or file a claim with the group insurance programs.

SCRIPT FOR GROUP ACCIDENT INSURANCE

Below is an outline of a script along with the verification / applicant signature script to follow when conducting sales for the Group Accident Insurance that is underwritten by United States Fire Insurance Company. As long as the general practice and points of the script is followed, it doesn't have to be word for word since all conversations flow in different ways with different sales. All main points of the script outline must be part of the required sales recording that must be completed and saved for every new member. This will help protect you for any potential complaints you could have in the future from a disgruntled or unhappy member.

BASIC STARTING SCRIPT OUTLINE (an outline of points that need to be addressed in recording)

The [PLAN NAME] includes Group Accident Insurance underwritten by United States Fire Insurance Company and includes the following:

- Schedule of Benefits information for the **[PLAN NAME / CLASS]** chosen (page 5 in Agent Guide for reference)
- Explain the Full Excess (in NE it is Primary Medical Expense) and how it works (pages 7-11 in Agent Guide for reference)
- Explain the Accidental Death & Dismemberment Description of Benefits (page 14 in Agent Guide for reference)
- Explain the Accident Medical Expense Benefits (pages 15-19 in Agent Guide for reference)
- Send the member a pdf copy of the state-specific Certificate of Insurance by email so that they can review the insurance details along with the Limitations and Exclusions so that you can answer any questions that they might have on the coverage. Make sure that discuss this point that you have sent them a copy of the Certificate to review in your sales presentation.
- Answer any questions based on the STATE in which the member resides. Read all disclaimers. Then complete the application or send your unique link for them to complete the application. Instruct and explain to the potential member that they will receive an email for the verification, application review and e-signature to complete and that the application process will not be completed unless the application is reviewed, accepted and e-signed by them.
- Follow the Application Signature for Recording Script before ending the sales call recording. Keep recording of sales call. We will conduct random audits each year and your call could be requested for review.

APPLICANT SIGNATURE FOR RECORDING

You attest to the best of your knowledge and belief that the answers to the questions on the Enrollment application are true and complete. You understand that the Group Accident Insurance provided as part of **[PLAN NAME]** is issued and underwritten by United States Fire Insurance Company.

Sign your application by completing the verification review and e-signature process from the email or text link that you received. Your signature will be saved to your application along with your IP address and the current date & time. You agree that your electronic signature will serve as your original signature, and by signing you agree to all acknowledgments, agreements, authorizations, and certifications that have been presented to you based on the memberships, plans, or products you've selected.

You hereby request to enroll in **[PLAN NAME]** and the UBA Membership through United Business Association. You have reviewed both **[PLAN NAME]** and the UBA Membership. You understand and agree to all terms and conditions, limitations and exclusions and state availability of coverage that may apply to the plans you are purchasing. You authorize H A Partners, Inc., the Administrator of these products, to charge all monthly premiums / dues for these products to the credit card or bank account you provided. You attest that you are the owner of, an authorized signer on, or have been granted express authority to use, the credit card or bank account provided for this purchase. You understand that it is your responsibility to check the transactions occurring on your account every month. You understand and agree that membership services and the insurance premiums for any applicable group insurance programs are paid for on your behalf, whether or not you use the membership services or file a claim with any applicable group insurance programs. You agree that this Authorization is to remain in full force until revoked by me in writing to 409 W Vickery Blvd, Fort Worth, TX 76104, by email at info@ubamembers.com, cancellation form at ubamembers.com, or by phone 866-438-4274.

You understand that if the Enrollment is accepted by the Company, coverage will begin on the Requested Effective Date, subject to the payment of the required premium. Coverage will not become effective unless you meet all eligibility requirements on the date of the enrollment and the effective date of coverage.

(NOTE: Review with the potential member all state specific disclaimers and fraud warnings.)