GROUP BENEFITS FIXED INDEMNITY INSURANCE FOR YOUR **SUPPLEMENTAL INSURANCE NEEDS**

AGENT VERSION

not for consumer use

CRUM & FORSTER

A FAIRFAX COMPANY

Group Benefits Fixed Indemnity Insurance & Critical Illness Rider 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 Benefits Fixed Indemnity & Critical Illness Insurance Rider

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 Benefits Fixed Indemnity Insurance and Critical Illness Rider 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 Benefits Fixed Indemnity Insurance underwritten 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
- Underwriting Questions (Member & Spouse only)

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 Benefits Fixed Indemnity Insurance and Critical Illness Insurance Rider 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 Benefits Fixed Indemnity Insurance and the Critical Illness Rider 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 Benefits Fixed Indemnity, 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 - GROUP BENEFITS FIXED INDEMNITY

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

ELIGIBILITY FOR INSURANCE

Persons eligible to be insured under the Policy are those persons described as being in a Class of Eligible Persons 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.

An Insured Person's Dependent(s), as defined, are eligible on the latest of the date:

1) the Insured Person is eligible, if the Insured Person has Dependents on that date; or

2) the date the person becomes a Dependent.

If the Insured Person is in a Class of Eligible Persons and is also eligible as a Dependent, they may be covered only once under the Policy. In no event will a Dependent be eligible if the Insured Person is not eligible.

CLASSES OF ELIGIBLE PERSONS*

A person may be covered only under one Class of Eligible Persons even though the person may be eligible under more than one class. Also, a person may not be covered as a Dependent and an Insured Person at the same time.

Class I:

Members of the Policyholder **age 18-65**.

Class II:

Spouse /Civil Union Partner/Domestic Partner of Class I when such Spouse /Civil Union Partner Domestic Partner is **under age 65**.

Class III:

Dependent Child(ren) of Class I and Class II (**up to age 26 in all states but TX, which is up to age 25 & NE which is under age 30.**)

*__Georgia__ has a variation based GA Certificate.
Class II: Spouse / Domestic Partner of Class 1 when Spouse / Domestic Partner is under age 65.

This is a very brief description of the Group Hospital Fixed Indemnity Insurance and Critical Illness rider 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.

CERTIFICATE COVER SHEET DISCLAIMERS

Below are the disclaimers listed on the Certificate of Insurance for the Group Benefits Fixed Indemnity Insurance underwritten by United States Fire Insurance Company. There could be some variations by state or additional disclaimers by state. Below is based on the TX Certificate and any variations by state will be listed below.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS CERTIFICATE DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DOES NOT SATISFY THE REQUIREMENT OF MINIMUM ESSENTIAL COVERAGE UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED, AND/OR ANY RELATED LEGISLATION.

PLEASE READ THIS CERTIFICATE CAREFULLY.

ARIZONA VARIATIONS:

Below is an additional disclaimer on the Arizona Certificate of Insurance only:

NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.

The Policy is a legal contract between the Policyholder and United States

GEORGIA VARIATIONS:

Below is an additional disclaimer on the Georgia Certificate of Insurance only:

THE POLICY DOES NOT COVER MENTAL ILLNESS.

NEBRASKA VARIATIONS:

Below is an additional disclaimer on the Nebraska Certificate of Insurance only:

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. IF A COVERED PERSON IS ELIGIBLE FOR MEDICARE, THEY SHOULD REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM THE COMPANY.

NORTH CAROLINA VARIATIONS:

Below are additional disclaimers on the North Carolina Certificate of Insurance only:

The Policy is governed by the laws of the state where it was delivered. This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but is issued under a group master policy located in another state and may be governed by that state's laws.

A PRE-EXISTING CONDITION LIMITATION MAY APPLY. PLEASE READ YOUR CERTIFICATE CAREFULLY. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

Important Cancellation Information - Please Read The Provision Entitled, Termination Date of Insurance, Found On Page 13.

OKLAHOMA VARIATIONS:

Below are the additional disclaimers on the Oklahoma Certificate of Insurance only:

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

NOTICE: The Policyholder has the right to return the Policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the Policy, the Policyholder is not satisfied for any reason. If We do not return any premiums or money paid therefore within thirty (30) days from the date of cancellation, We will pay interest on the proceeds.

TENNESSEE VARIATIONS:

Below is an additional disclaimer on the Tennessee Certificate of Insurance only:

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

TEXAS VARIATIONS:

Below is an additional disclaimer on the Texas Certificate of Insurance only:

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT B COME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This is a very brief description of the Group Benefits Fixed Indemnity Insurance and Critical Illness Rider 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.

SM&RT MED

Hospital Indemnity Benefit	Sm&rt Med Membership Plan Options			
	Premium	Plus	Value	Basic
Lifetime Maximum per Covered Person	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Benefit Waiting Period for Sickness: Hospital Confinement Benefit, Inpatient and Outpatient Surgery Benefit, Inpatient and Outpatient Surgery Anesthesia Benefit, Outpatient Diagnostic Exam, X-Rays and Lab Tests	30 Days	30 Days	30 Days	30 Days
Hospital Admission Benefit **up to 1 occurrence per Certificate Period** Benefit is payable in addition to Hospital Confinement Benefit	$3,000	$2,000	$1,000	$1,000
Hospital Confinement Benefit **Per day for days 2-30 for a Hospital Confinement occurring in a Certificate Period** and subject to a Maximum benefit of $1,000,000 per Certificate Period.	$6,000	$4,000	$3,000	$2,000
Emergency Care Benefit for Sickness and Injury (TX) Emergency Room Visits Benefit for Sickness and Injury (all other states) **Per Day up to a Maximum Benefit of # days per Certificate Period** for Injury and Sickness combined	$300	$300	$250	$250
	2 days	2 days	1 day	1 day
Inpatient Surgery Benefit **Per day up to a Maximum Benefit of 1 day per Certificate Period**	$9,000	$5,000	$4,000	$1,000
Inpatient Surgery Anesthesia Benefit **Per day up to a Maximum Benefit of 1 day per Certificate Period**	$2,250	$1,250	$1,000	$250
Outpatient Surgery Benefit **Per day up to a Maximum Benefit of 1 day per Certificate Period**	$3,000	$2,500	$2,000	$1,000
Outpatient Surgery Anesthesia Benefit **Per day up to a Maximum Benefit of 1 day per Certificate Period**	$600	$350	$250	$70
Wellness Office Visits Benefit **Per day up to a Maximum Benefit of 4 days per Certificate Period** for Wellness visits to a Medical Professional.	$25	$25	$25	$25
Wellness Tests Benefit **Per day up to a Maximum Benefit of 3 days per Certificate Period.** Wellness tests ordered by Medical Professional or Specialist including: Pap Smear Test, Prostate Cancer Screening, Mammography. Does not include Lab or Radiology Tests.	$300	$300	$250	$250
Ambulance Benefits - Air Benefit **Per day up to 1 day per Injury or Sickness and up to a Maximum Benefit of 1 day per Certificate Period**. Air Ambulance transportation must occur within 1 day after the Covered Accident or Sickness occurs.	$1,500	$1,500	$1,500	$1,500
Ambulance - Ground or Water Benefit **Per day up to 2 days per Injury or Sickness and up to a Maximum Benefit of 2 days per Certificate Period**. Ground or Water Ambulance transportation must occur within 1 day after the Covered Accident or Sickness occurs.	$150	$150	$150	$150
Prescription Drug Benefit **Per day up to a Maximum Benefit of # days per Certificate Period.**	$75	$50	$50	$25
	10 days	15 days	15 days	30 days
Diagnostic Exam - Outpatient Only Benefit **Per day for up to 3 days per Injury or Sickness and up to a Maximum Benefit of 3 days per Certificate Period.** The Diagnostic Exam must occur within 90-days after the Covered Accident or Sickness occurs.	$700	$600	$500	$300
X-Ray - Outpatient Only Benefit **Per Day for up to 1 day per Injury or Sickness and up to a Maximum Benefit of 1 day per Certificate Period**. The X-Ray must occur within 90-days after the Covered Accident or Sickness occurs.	$250	$250	$200	$200
Lab Test - Outpatient Only Benefit **Per day for up to 2 days per Injury or Sickness and up to a Maximum Benefit of 2 days per Certificate Period**. The Lab Test must occur within 90-days after the Covered Accident or Sickness occurs.	$350	$350	$250	$250
Therapy Services Visit Benefit **Per day for up to # days per Injury or Sickness and up to a Maximum Benefit of # days per Certificate Period**. Therapy Services must begin within 90-days after the Covered Accident or Sickness occurs and be rendered within 180-days (90-days in KY, NC & NE) after the Covered Accident or Sickness occurs.	$75	$75	$50	$50
	12 days	12 days	8 days	8 days

Please make sure to review the Certificate of insurance, Schedule of Benefits and Rider for full benefit details, definitions, terms, limitations and exclusions. ***If there are any discrepancies between this brochure and the Certificate and Rider, the Certificate and Rider shall govern. Pre-Existing Limitations apply to some Benefits.***

SM&RT MED

Critical Illness Benefit Rider	Sm&rt Med Membership Plan Options			
	Premium	Plus	Value	Basic
Critical Illness Benefit Amount per Covered Person (1 per lifetime)	$25,000	$15,000	$10,000	$5,000
Benefit Waiting Period per Covered Person	30 Days	30 Days	30 Days	30 Days
Covered Critical Illness Covered Conditions				
Cardiac	**Percentage of Critical Illness Benefit Amount**			
Heart Attack (Myocardial Infarction)	100%			
Sudden Cardiac Arrest	100%			
Coronary Artery Disease requiring Coronary Artery Bypass	25%			
Coronary Artery Disease requiring Angioplasty	100%			
Cerebral Vascular Disease	**Percentage of Critical Illness Benefit Amount**			
Stroke	100%			
Ruptured Brain Aneurysm	100%			
Transient Ischemic Attack	100%			
Other Specified Illness	**Percentage of Critical Illness Benefit Amount**			
Bone Marrow / Stem Cell Transplant	100%			
Coma	100%			
End Stage Renal (Kidney) Failure	100%			
Major Organ Failure requiring Transplant	100%			
Occupational Infectious Hepatitis B, C, or D	100%			
Occupational Infectious HIV	100%			
Benign Brain Tumor	100%			
Permanent Paralysis	**Percentage of Critical Illness Benefit Amount**			
Quadriplegia	100%			
Paraplegia	100%			
Hemiplegia / Diplegia	100%			
Other Accident	**Percentage of Critical Illness Benefit Amount**			
Severe Burns Covered Dependent Children are not covered for Severe Burns (except in NE & TN).	100%			
Cancer	**Percentage of Critical Illness Benefit Amount**			
Invasive	100%			
Non-Invasive	25%			
Skin Cancer (per lifetime)	$100			

You must submit a claim form to access the group insurance coverage in the Sm&rt Med membership plans and provide the required items listed on the claim form. Claims Administrator is **Health Special Risk (HSR): 866-423-3452 | ubaclaims@hsri.com**.

Download the claim form for Sm&rt Med Membership plans at: **https://www.ubamembers.com/claimforms.html.**

Please make sure to review the Certificate of insurance, Schedule of Benefits and Rider for full benefit details, definitions, terms, limitations and exclusions. ***If there are any discrepancies between this brochure and the Certificate and Rider, the Certificate and Rider shall govern.***

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the **Group Benefits Fixed Indemnity Insurance** issued by United States Fire Insurance Company based on the TX Certificate of Insurance. Benefits are only provided while the Covered Person's coverage is effective. These benefits are subject to the Maximum Benefit amounts and other terms or limits, such as number of sessions, shown below and in the Schedule of Benefits. Benefits will not duplicate any other benefits payable under the Certificate or any coverage(s) attached to the Certificate unless otherwise stated in the Schedule of Benefits. Benefits could vary or not be available in all states. Any state variation in the language of the descriptions will be shown along with a linking page number for you to view the variation.

Group Benefits Fixed Indemnity Insurance Benefit[1]	DESCRIPTION OF BENEFIT[1]
Hospital Admission Benefit	Hospital Admission Benefit We will pay the Hospital Admission Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined and all of the following conditions are met: 1. the Hospital Stay is Medically Necessary and the direct result, from no other causes, of Injuries or illness sustained in a Covered Accident or from a Sickness; and 2. the Hospital Stay is the first day of Hospital Confinement for the Covered Person during the Certificate Period. **This benefit will be paid in addition to the Hospital Confinement Benefit.**
Hospital Confinement Benefit	Hospital Confinement Benefit We will pay the Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined as an Inpatient and all of the following conditions are met: 1. the Hospital Stay is Medically Necessary and the direct result, from no other causes, of Injuries or illness sustained in a Covered Accident or from a Sickness; and 2. Hospital Confinement is at the direction and under the care of a Medical Professional; and 3. while the Covered Person's coverage is in effect. Benefit payments will end on the first of the following dates: 1. the date the Hospital stay ends; or 2. the date the Covered Person dies; or 3. the date the Maximum Benefit for this benefit is payable; or 4. the date insurance under the Policy ends for the Covered Person.
Emergency Care Benefit for Sickness and Injury *(This is the description only in* **TX***)*	Emergency Care Benefit for Sickness and Injury We will pay the benefit shown in the Schedule of Benefits for Emergency Care if a Covered Person requires Emergency Care treatment as the result of an Injury due to a Covered Accident or a Sickness.
Emergency Room Visits Benefit for Sickness and Injury *(This is the description in* **all states except TX***)*	Emergency Room Visits Benefit for Sickness and Injury We will pay the benefit shown in the Schedule of Benefits for Emergency Room visits if a Covered Person requires Hospital Emergency Room treatment for a Medical Emergency as the result of an Injury due to a Covered Accident or a Sickness.

This is a very brief description of the Group Benefits Fixed Indemnity 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.

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Group Benefits Fixed Indemnity Insurance Benefit[1]	DESCRIPTION OF BENEFIT[1]
Inpatient Surgery Benefit	Inpatient Surgery Benefit We will pay the Inpatient Surgery Benefit shown in the Schedule of Benefits if a Covered Person is ordered by a Medical Professional to undergo Medically Necessary Surgery as the result of a Covered Accident or Sickness. Inpatient Surgery must be performed in the operating room of a Hospital.
Inpatient Surgery Anesthesia Benefit	Inpatient Surgery Anesthesia Benefit We will pay the Inpatient Surgery Anesthesia Benefit shown in the Schedule of Benefits if a Covered Person is administered anesthesia on an Inpatient basis for a Medically Necessary Surgery as the result of a Covered Accident or Sickness.
Outpatient Surgery Benefit	Outpatient Surgery Benefit We will pay the Outpatient Surgery Benefit shown in the Schedule of Benefits if a Covered Person is ordered by a Medical Professional to undergo Medically Necessary Surgery as the result of a Covered Injury or Sickness. Outpatient Surgery must be performed in the Outpatient department of a Hospital or an Ambulatory Surgical Center.
Ambulatory Surgical Center	Ambulatory Surgical Center means a free standing facility providing ambulatory surgical or medical treatment other than a Hospital, clinic, Medical Professional's or Specialist's office. It must be qualified to provide the treatment under the standards set by the state in which it is located.
Outpatient Surgery Anesthesia Benefit	Outpatient Surgery Anesthesia Benefit We will pay the Outpatient Surgery Anesthesia Benefit shown in the Schedule of Benefits if a Covered Person is administered anesthesia on an Outpatient basis for a Medically Necessary Surgery as the result of a Covered Accident or Sickness.

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Group Benefits Fixed Indemnity Insurance Benefit[1]	DESCRIPTION OF BENEFIT[1]
Wellness Office Visits Benefit	Wellness Office Visits Benefit We will pay the benefit shown in the Schedule of Benefits for Wellness Office Visits if a Covered Person visits a Medical Professional. These services will be covered only to the extent that they are provided by, or under the supervision of a Medical Professional during the course of one visit. Services include visits to receive immunizations as provided by department of health regulation. **Tennessee** has a variation based on the TN Certificate. **See page 15** for variation of description.
Wellness Tests Benefit *(This is the description only in **TX**)*	Wellness Tests Benefit We will pay the benefit shown in the Schedule of Benefits for Wellness Tests if the tests are ordered by a Medical Professional and performed by a Medical Professional, Specialist or an appropriately licensed technician. This includes pap smear test, Prostate Cancer Screening, mammography. This does not include Laboratory Tests or Radiology Tests.
Wellness Tests Benefit *(This is the description in **all states <u>except</u> TX**)*	Wellness Tests Benefit We will pay the benefit shown in the Schedule of Benefits for Wellness Tests if the tests are ordered by a Medical Professional and performed by an appropriately licensed technician. This includes pap smear test, Prostate Cancer Screening, mammography. This does not include Laboratory Tests or Radiology Tests.
Prostate Cancer Screening	Prostate Cancer Screening means a PSA test and/or Digital Rectal Exam.
Air Ambulance Benefit	Air Ambulance Benefit We will pay the Ambulance - Air Benefit shown in the Schedule of Benefits, subject to the following conditions, if the Covered Person requires Air Ambulance services due to a Covered Accident or Sickness. The Air Ambulance services provided must be for transportation from the scene of the Covered Accident to the nearest Hospital that is able to provide appropriate care, or in the event of a Sickness, the Medically Necessary transportation to a Hospital. This benefit is payable for up to 1 day per Injury or Sickness and up to a Maximum Benefit of 1 day per Certificate Period for each Covered Person. Air Ambulance transportation must occur within 1 day after the Covered Accident or Sickness occurs. If more than one form of ambulance transport occurs on the same day, only the highest ambulance benefit is payable.
Air Ambulance	Air Ambulance means air transportation provided by a licensed professional ambulance company in a vehicle designed, equipped and used only to transport the sick or injured to the closest local facility that can provide the medical care appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area.

This is a very brief description of the Group Benefits Fixed Indemnity 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.

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Group Benefits Fixed Indemnity Insurance Benefit[1]	DESCRIPTION OF BENEFIT[1]
Ambulance - Ground or Water Benefit	Ambulance – Ground or Water Benefit We will pay the Ambulance – Ground or Water Benefit shown in the Schedule of Benefits, subject to the following conditions, if the Covered Person requires Ground or Water Ambulance services due to a Covered Accident or Sickness. The Ground or Water Ambulance services provided must be for transportation from the scene of the Covered Accident to the nearest Hospital that is able to provide appropriate care, or in the event of a Sickness, the Medically Necessary transportation to a Hospital. This benefit is payable for up to 2 days per Injury or Sickness and up to a Maximum Benefit of 2 days per Certificate Period for each Covered Person. Ground or Water Ambulance transportation must occur within 1 day after the Covered Accident or Sickness occurs. If more than one form of ambulance transport occurs on the same day, only the highest ambulance benefit is payable.
Ground Ambulance	Ground Ambulance means transportation provided by a licensed professional ambulance company in a vehicle designed, equipped and used only to transport the sick or injured to a Hospital. Surface trips must be to the closest local facility that can provide the medical care appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area.
Water Ambulance	Water Ambulance means transportation provided by a licensed professional ambulance company in a publicly or privately owned vessel that is specifically designed, constructed or modified and equipped, and intended to be used for and is maintained or operated for the transportation upon the waterways to transport the sick or injured to the closest local facility that can provide the medical care appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area.
Prescription Drug Benefit	Prescription Drug Benefit We will pay the benefit shown in the Schedule of Benefits for Medically Necessary Prescription Drugs that are purchased by a Covered Person for treatment within 30 days of a Covered Accident or Sickness. The following are not considered to be Medically Necessary Prescription Drugs and these medications are specifically not covered under this Benefit: 1. Over-the-counter medications, supplies or products; 2. Medications or other agents to increase or enhance fertility or the likelihood of conception; 3. Medications for the treatment of erectile dysfunction or to assist in or enhance sexual performance; 4. Vitamins and or nutritional supplements; 5. Medications to eliminate or reduce a dependency or an addiction to tobacco including, but not limited to, the cessation or termination of cigarette, cigar, or tobacco smoking or the use of smokeless tobacco, including nicotine products, gums and transdermal patches; 6. Medications for the treatment of hair loss or for the purpose of regrowing lost hair, such as Rogaine, Minoxidil; 7. Immunization agents, biological sera, blood or blood plasma; 8. Medications for the treatment or obesity or diet control; 9. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use; 10. Homeopathic medications; 11. Any medication purchased outside the United States of America. **Kentucky** has a variation based on the KY Certificate. **See page 15** for variation of description.

This is a very brief description of the Group Benefits Fixed Indemnity 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.

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Group Benefits Fixed Indemnity Insurance Benefit[1]	DESCRIPTION OF BENEFIT[1]
Diagnostic Exam - Outpatient Only Benefit	Diagnostic Exam -Outpatient Only Benefit We will pay the Diagnostic Exam -Outpatient Only Benefit amount shown in the Schedule of Benefits for each day that a Covered Person undergoes a Diagnostic Exam on an Outpatient basis for the purpose of diagnosing an Injury or Sickness. The Diagnostic Exam must occur within 90 days after the Covered Accident or Sickness occurs. This benefit will not be paid for a Diagnostic Exam that occurs on an Inpatient basis. This benefit is only payable once per day, even if more than one Diagnostic Exam occurs or the Diagnostic Exam is for more than one Injury or Sickness. If more than one Diagnostic Exam or Lab Test or X-Ray occurs on the same day, only the highest applicable benefit is payable.
Diagnostic Exam	Diagnostic Exam means any of the following major/advanced tests: angiogram, arteriogram, bone scintigraphy, CT, EEG, EKG, EMG, MRI, PET, SPECT, or thallium stress test. This definition does not include any Lab Test or XRay.
X-Ray - Outpatient Only Benefit	X-Ray -Outpatient Only Benefit We will pay the X-Ray -Outpatient Only Benefit amount shown in the Schedule of Benefits for each day that a Covered Person undergoes an X-Ray on an Outpatient basis for the purpose of diagnosing an Injury or Sickness. The X-Ray must occur within 90 days after the Covered Accident or Sickness occurs. This benefit will not be paid for an X-Ray that occurs on an Inpatient basis. This benefit is only payable once per day, even if more than one X-Ray occurs or the X-Ray is for more than one Injury or Sickness. If more than one X-Ray or Diagnostic Exam or Lab Test occurs on the same day, only the highest applicable benefit is payable.
Lab Test - Outpatient Only Benefit	Lab Test -Outpatient Only Benefit We will pay the Lab Test -Outpatient Only Benefit amount shown in the Schedule of Benefits for each day that a Covered Person undergoes a Lab Test on an Outpatient basis for the purpose of diagnosing an Injury or Sickness. The Lab Test must occur within 90 days after the Covered Accident or Sickness occurs. This benefit will not be paid for a Lab Test that occurs on an Inpatient basis. This benefit is only payable once per day, even if more than one Lab Test occurs or the Lab Test is for more than one Injury or Sickness. If more than one Lab Test or X-Ray or Diagnostic Exam occurs on the same day, only the highest applicable benefit is payable.
Lab Tests	Lab Test means a laboratory study of human blood, bodily tissues or fluids, such as a blood chemistry or urinalysis. This definition does not include any Diagnostic Exam or X-Ray.

This is a very brief description of the Group Benefits Fixed Indemnity 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

The following provisions explain the benefits available under the **Group Benefits Fixed Indemnity Insurance** issued by United States Fire Insurance Company based on the TX Certificate of Insurance. Benefits are only provided while the Covered Person's coverage is effective. These benefits are subject to the Maximum Benefit amounts and other terms or limits, such as number of sessions, shown below and in the Schedule of Benefits. Benefits will not duplicate any other benefits payable under the Certificate or any coverage(s) attached to the Certificate unless otherwise stated in the Schedule of Benefits. Benefits could vary or not be available in all states. Any state variation in the language of the descriptions will be shown along with a linking page number for you to view the variation.

Group Benefits Fixed Indemnity Insurance Benefit[1]	DESCRIPTION OF BENEFIT[1]
Therapy Services Visit Benefit	Therapy Services Visit Benefit We will pay the Therapy Services Visit Benefit amount shown in the Schedule of Benefits for each day that a Covered Person receives Therapy Services from a Therapist in the Therapist's office or clinic as the result of an Injury or Sickness. The Therapy Services must be prescribed by a Medical Professional, or recommended by a Medical Professional for acupuncture or chiropractic care. This benefit is only payable once per day, even if Therapy Services are received for more than one Injury or Sickness. Therapy Services must begin within 90 days after the Covered Accident or Sickness occurs and be rendered within 180 days after the Covered Accident or Sickness occurs. This benefit will not be paid for any day for which any Hospital Confinement benefit is payable. **Kentucky** has a variation based on the KY Certificate. **See page 15** for variation of description. **Nebraska** has a variation based on the NE Certificate. **See page 15** for variation of description. **North Carolina** has a variation based on the NC Certificate. **See page 15** for variation of description.
Therapist	Therapist means a person who is appropriately licensed to practice and provide acupuncture, chiropractic care, occupational therapy, physical therapy or speech therapy. Such Therapist must be acting within the scope of their license. A Therapist does not include the Covered Person or the Covered Person's Immediate Family Member. **Arizona** has a variation based on the AZ Certificate. **See page 15** for variation of description. **Georgia** has a variation based on the GA Certificate. **See page 15** for variation of description.
Therapy Services	Therapy Services means acupuncture, chiropractic care, occupational therapy, physical therapy or speech therapy.

This is a very brief description of the Group Benefits Fixed Indemnity 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.

STATE VARIATIONS AND ADDITIONS

BENEFIT DESCRIPTION STATE VARIATIONS - GROUP BENEFITS INDEMNITY INSURANCE

In this section of the agent guide, all of the state variations that are different from the benefit descriptions listed between pages 8-13 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

Group Benefits Fixed Indemnity Insurance Benefit[1]	DESCRIPTION OF BENEFIT[1]
ARIZONA	
Therapist	Therapist means a person who is appropriately licensed to practice and provide acupuncture, chiropractic care, occupational therapy, physical therapy or speech therapy. Such Therapist must be acting within the scope of their license. A Therapist includes a Physician, but does not include the Covered Person.
GEORGIA	
Therapist	Therapist means a person who is appropriately licensed to practice and provide acupuncture, chiropractic care, occupational therapy, physical therapy or speech therapy. Such Therapist must be acting within the scope of their license. A Therapist does not include the Covered Person or the Covered Person's Immediate Family Member or Domestic Partner.
KENTUCKY	
Therapy Services Visit Benefit	Therapy Services Visit Benefit We will pay the Therapy Services Visit Benefit amount shown in the Schedule of Benefits for each day that a Covered Person receives Therapy Services from a Therapist in the Therapist's office or clinic as the result of an Injury or Sickness. The Therapy Services must be prescribed by a Medical Professional, or recommended by a Medical Professional for acupuncture or chiropractic care. This benefit is only payable once per day, even if Therapy Services are received for more than one Injury or Sickness. Therapy Services must begin within 90 days after the Covered Accident or Sickness occurs and be rendered within 90 days after the Covered Accident or Sickness occurs. This benefit will not be paid for any day for which any Hospital Confinement benefit is payable
NEBRASKA	
Therapy Services Visit Benefit	Therapy Services Visit Benefit We will pay the Therapy Services Visit Benefit amount shown in the Schedule of Benefits for each day that a Covered Person receives Therapy Services from a Therapist in the Therapist's office or clinic as the result of an Injury or Sickness. The Therapy Services must be prescribed by a Medical Professional, or recommended by a Medical Professional for acupuncture or chiropractic care. This benefit is only payable once per day, even if Therapy Services are received for more than one Injury or Sickness. Therapy Services must begin within 90 days after the Covered Accident or Sickness occurs and be rendered within 90 days after the Covered Accident or Sickness occurs. This benefit will not be paid for any day for which any Hospital Confinement benefit is payable.
NORTH CAROLINA	
Therapy Services Visit Benefit	Therapy Services Visit Benefit We will pay the Therapy Services Visit Benefit amount shown in the Schedule of Benefits for each day that a Covered Person receives Therapy Services from a Therapist in the Therapist's office or clinic as the result of an Injury or Sickness. The Therapy Services must be prescribed by a Medical Professional, or recommended by a Medical Professional for acupuncture or chiropractic care. This benefit is only payable once per day, even if Therapy Services are received for more than one Injury or Sickness. Therapy Services must begin within 90 days after the Covered Accident or Sickness occurs and be rendered within 90 days after the Covered Accident or Sickness occurs. This benefit will not be paid for any day for which any Hospital Confinement benefit is payable.
TENNESSEE	
Wellness Office Visits Benefit	Wellness Office Visits Benefit We will pay the benefit shown in the Schedule of Benefits for Wellness Office Visits if a Covered Person visits a Medical Professional for an annual routine examination or well child care. These services will be covered only to the extent that they are provided by, or under the supervision of, a Medical Professional during the course of one visit. Services include visits to receive immunizations as provided by department of health regulation.

DEFINITIONS

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Accident *(This is the **TX Definition only**)*	Accident means an event which: (1) Causes Injury to one or more Covered Persons; and (2) Occurs while coverage is in effect for the Covered Person.
Accident *(This is the definition for **all other states** except TX)*	Accident means a sudden, unforeseeable event which: (1) Causes Injury to one or more Covered Persons; and (2) Occurs while coverage is in effect for the Covered Person.
Certificate Holder	Certificate Holder means the Insured Person to whom an insurance Certificate has been issued evidencing coverage under the Policy.
Certificate Period	Certificate Period means the period of time specified in the Schedule of Benefits.
Child or Children	Child or Children means the Insured Person's natural child, adopted child, foster child, stepchild, or other child for whom the Insured Person has legal guardianship (proof will be required). A child is considered to be the adopted child of the Insured Person if the Insured Person is a party to a suit in which the Insured Person seeks to adopt the child. Other than a foster child, all Dependent newborn children are covered beginning from the moment of birth. Child also includes an Insured Person's unmarried grandchild if the grandchild is under 25 years of age and is a dependent of the Insured Person for federal income tax purposes at the time coverage of the grandchild begins. Coverage for a grandchild may not be terminated solely because the covered child is no longer a dependent of the Insured Person for federal income tax purposes. Child also includes a child for whom the Insured Person must provide medical support under an order issued under Section 14.061, Family Code, or enforceable by a court in Texas. **Arizona** has a variation based on the AZ Certificate. **See page 29** for variation of definition. **Georgia** has a variation based on the GA Certificate. **See page 30** for variation of definition. **Kentucky** has a variation based on the KY Certificate. **See page 32** for variation of definition. **Mississippi** has a variation based on the MS Certificate. **See page 33** for variation of definition. **Nebraska** has a variation based on the NE Certificate. **See page 34** for variation of definition. **North Carolina** has a variation based on the NC Certificate. **See page 35** for variation of definition. **Oklahoma** has a variation based on the OK Certificate. **See page 36** for variation of definition. **Tennessee** has a variation based on the TN Certificate. **See page 37** 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 Benefit Fixed Indemnity 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.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Civil Union Partner	Civil Union Partner means the parties to a civil union who 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 the terms 'marriage' or 'married' or variations thereon. The term Spouse or Dependent includes civil union couples whenever used. **Georgia** does not have this definition in the GA Certificate of Insurance.
Company	Company means United States Fire Insurance Company. Also hereinafter referred to as We, Us and Our.
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; • Medical Professional 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. **Georgia** has a variation based on the GA Certificate. **See page 30** for variation of definition. **Tennessee** has a variation based on the TN Certificate. **See page 37** for variation of definition.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
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 Injury or Sickness covered under the Policy 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, for whom proper premium payment has been made when due, and who is therefore insured under the Policy.
Dependent	Dependent means an Insured Person's: 1) lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner; 2) unmarried Children **under age 25**. The age limitations will not apply to an Insured Person's unmarried Child who is incapable of self-sustaining employment by reason of mental retardation or physical disability. Proof of such incapacity must be furnished to the Company immediately upon enrollment or 31 days after the Child reaches 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. **Arizona** has a variation based on the AZ Certificate. **See page 29** for variation of definition. **Georgia** has a variation based on the GA Certificate. **See page 30** for variation of definition. **Kentucky** has addition to definition based on the KY Endorsement. **See page 32** for variation of definition. **Mississippi** has a variation based on the MS Certificate. **See page 33** for variation of definition. **Nebraska** has a variation based on the NE Certificate. **See page 34** for variation of definition. **North Carolina** has a variation based on the NC Certificate. **See page 35** for variation of definition. **Oklahoma** has a variation based on the OK Certificate. **See page 36** for variation of definition **Tennessee** has a variation based on the TN Certificate. **See page 37** for variation of definition.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Domestic Partner	Domestic Partner means an opposite or same sex partner who, for at least 6- consecutive months, has resided with the Insured Person and shared financial assets/obligations with the Insured Person. Both the Insured 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 Insured 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. **Georgia** has a variation based on the GA Certificate. **See page 30** for variation of definition.
Domestic Partner Registry *(This definition is **ONLY in GA** Certificate)*	Domestic Partner's Registry is a document/form provided by a municipality, county, city, or other political subdivision of the state, or other formalized document/form provided by an employer, true association, multiple employer trust which is a legal form, must be witnessed and notarized, signed under penalty of perjury for false swearing. Within such Domestic Partners Registry/Declaration/Affidavit form, the parties must state: • Parties must have lived together for a period of at least 12 months as Domestic Partners and must furnish reasonable proof of shared primary, regular and permanent residence address. • Parties must pledge financial reliance on one another for support. • Parties must affirm a committed, personal relationship with each other that is mutually interdependent and intended to be lifelong. • Parties agree to be jointly obligated and responsible for the necessities of life for each other. • Parties must not be married to anyone or legally separated from anyone. • Parties must be at least 18 years of age. • Parties are each competent to enter into a contract. • Parties are not related by blood closer than would bar marriage in the state of Georgia. • Parties are each other's sole Domestic Partner. • Parties agree to file a termination of Domestic Partnership within 30 days to the Registry sponsor if any of the facts set out in the Domestic Partners Registry/Affidavit/Document change.
Emergency Care *(This definition is **ONLY in TX** Certificate)*	Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that absence of immediate medical attention could reasonably be expected to result in: 1. Placing the patient's health in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part. Treatment for Emergency Care will be paid only for Sickness or Injury which fulfills the above conditions.
Emergency Room *(This definition is in **all other state's** certificates except TX)*	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, Medical Professional's or Specialist's office.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Experimental or Investigational	Experimental or Investigational means a service for which one or more of the following is true: 1. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. We will determine if this item 1. is true based on: A. Published reports in authoritative medical literature; and B. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the Food and Drug Administration (FDA). 2. In the case of a drug, a device or other supply that is subject to FDA approval: A. It does not have FDA approval; or B. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be: 1) Included in substantially accepted peer-reviewed medical literature such as: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services; 2) Included in a Prescription Drug reference compendium; or 3) In addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications. 3. The Medical Professional's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to the board's approval. 4. Research protocols indicate that the service or supply is Experimental or Investigational. This item 4 applies for protocols used by the Covered Person's Medical Professional as well as for protocols used by other Medical Professionals studying substantially the same service or supply. **Georgia** has a variation based on the GA Certificate. **See page 31** for variation of definition.
Gender Transition Procedures *(This definition is **ONLY in the MS** Certificate.)*	Gender Transition Procedures means any of the following medical or surgical services performed for the purpose of assisting an individual with a gender transition: 1. Prescribing or administering puberty-blocking drugs; 2. Prescribing or administering cross-sex hormones; or 3. Performing gender reassignment surgeries. Gender Transition Procedures do not include services to persons born with a medically verifiable disorder of sex development, including a person with external sex characteristics that are irresolvably ambiguous, such as those born with forty-six (46) XX chromosomes with virilization, forty-six (46) XY chromosomes with undervirilization, or having both ovarian and testicular tissue.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Hospital	Hospital means an institution licensed, accredited or certified by the State that: 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons; 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call; 4) Has a staff of one or more licensed Medical Professionals available at all times; 5) Provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities. We will not deny a claim of a non-indigent Covered Person for treatment in a Hospital facility that: 1) is owned or controlled by the State of Texas or by a unit of local government; and 2) regularly and customarily demands and collects from non-indigent persons payment for such treatment. In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness not related to acquired brain injury or substance abuse, except as specifically stated. **Arizona** has a variation based on the AZ Certificate. **See page 29** for variation of definition. **Georgia** has a variation based on the GA Certificate. **See page 31** for variation of definition. **Kentucky** has a variation based on the KY Certificate. **See page 32** for variation of definition. **Mississippi** has a variation based on the MS Certificate. **See page 33** for variation of definition. **Nebraska** has a variation based on the NE Certificate. **See page 34** for variation of definition. **North Carolina** has a variation based on the NC Certificate. **See page 35** for variation of definition. **Oklahoma** has a variation based on the OK Certificate. **See page 36** for variation of definition. **Tennessee** has a variation based on the TN Certificate. **See page 38** for variation of definition.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Hospital Stay or Hospital Confinement *(This is the **TX definition only**.)*	Hospital Stay or Hospital Confinement means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a charge is made by the Hospital. One period of Hospital Confinement means consecutive days of in-Hospital service received as an Inpatient, or successive confinements when discharge from and readmission to the Hospital occurs within a period of time not more than 90 days or three times the maximum number of days of Hospital Confinement coverage provided by the Policy to a maximum of 180 days.
Hospital Stay or Hospital Confinement *(This is the definition in **all other states** except TX.)*	Hospital Stay or Hospital Confinement means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a charge is made by the Hospital.
Immediate Family Member	Immediate Family Member means a Covered Person's Spouse, Domestic Partner, Civil Union Partner, parent, Child(ren) (includes legally adopted or step child(ren), brother, sister, grandchild(ren), or in-laws. **Georgia** has a variation based on the GA Certificate. **See page 31** for variation of definition.
Injury	Injury means bodily Injury caused by the direct result of an Accident occurring after the effective date of a Covered Person's coverage under the Policy, while the Policy is in force as to the person whose Injury is the basis of the claim which results, directly and independently of disease, bodily infirmity and all other causes, in a Covered Loss. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.
Inpatient	Inpatient means a Covered Person who is charged for at least one (1) day's room and board from a Hospital; or more than 23 hours in an observation unit.
Insured Person	Insured Person means a person in a Class of Eligible Persons described in the Schedule of Benefits who has a direct relationship with the Policyholder, who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person under the Policy. A Dependent covered under the Policy is not an Insured Person.
Laboratory Tests	Laboratory Tests means the procedures that are intended to detect, identify, or quantify one or more significant substances, evaluate organ functions, or establish the nature of a condition or disease.
Medical Emergency *(This definition is in **all other state's** Certificates except TX)*	Medical Emergency means a Sickness or Injury for which the Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause: • His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child; • Serious disfigurement of the Covered Person; • His bodily functions would be seriously impaired; or • A body organ or part would be seriously damaged. Treatment for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions.

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Benefits Fixed Indemnity 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.

DEFINITIONS

The definitions below are for all **Group Benefits Fixed Indemnity 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. 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.

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Medically Necessary or Medical Necessity *(This is the **TX Definition ONLY**.)*	Medically Necessary or Medical Necessity means a treatment, drug, device, service, procedure or supply that is: 1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury, as determined by clinical analysis; 2) Prescribed or ordered by a Medical Professional or furnished by a Hospital; 3) Performed in the least costly type of 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. In order for a Hospital confinement to be Medically Necessary, the diagnosis or treatment of symptoms or a condition must not be able to be safely provided on an Outpatient basis. The fact that a Medical Professional may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Policy. A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it: • Is Experimental or Investigational or for research purposes; • Is provided for education purposes or the convenience of the Covered Person, the Covered Person's family, Medical Professional , Hospital or any other provider; • Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care; • Could have been omitted without adversely affecting the person's condition or the quality of medical care; • Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration; • Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or • It can be safely provided to the patient on a more cost- effective basis, such as by Outpatient care, by a different Medical Professional, or pursuant to a more conservative form of treatment.
Medically Necessary or Medical Necessity *(This definition is for **all other state's** Certificates <u>except</u> TX)*	Medically Necessary or Medical Necessity means a treatment, drug, device, service, procedure or supply that is: 1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury; 2) Prescribed or ordered by a Medical Professional 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. In order for a Hospital confinement to be Medically Necessary, the diagnosis or treatment of symptoms or a condition must not be able to be safely provided on an Outpatient basis. The fact that a Medical Professional may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Policy. A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it: • Is Experimental or Investigational or for research purposes; • Is provided for education purposes or the convenience of the Covered Person, the Covered Person's family, Medical Professional , Hospital or any other provider; • Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care; • Could have been omitted without adversely affecting the person's condition or the quality of medical care; • Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration; • Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or • It can be safely provided to the patient on a more cost- effective basis, such as by Outpatient care, by a different Medical Professional, or pursuant to a more conservative form of treatment.

[1]This is a very brief description of the definitions in the TX Certificate of Insurance along with state variations for Group Benefits Fixed Indemnity 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.

DEFINITIONS

The definitions below are for all **Group Benefits Fixed Indemnity 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. 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.

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Medical Professional(s) *(This is the **TX definition only**.)*	Medical Professional(s) means a person who is a Physician or who is not a Physician but is appropriately licensed to provide some medical care and treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), acupuncturist, 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, podiatrist, psychological associate, psychologist, speech-language pathologist and surgical assistant. The Medical Professional must be acting within the scope of their license. A Medical Professional does not include a Covered Person or Covered Person's Immediate Family Member. This does not include holistic providers.
Medical Professional(s) *(This is the definition in **all other states** except GA, MS, NC & TX.)*	Medical Professional(s) means a person who is a Physician or who is not a Physician but is appropriately licensed to provide some medical care and treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). The Medical Professional must be acting within the scope of their license, relevant board certifications, and qualifications. If required by law, the Medical Professional must be under the supervision of a Physician. A Medical Professional does not include a Covered Person or Covered Person's Immediate Family Member. This does not include holistic providers. **Georgia** has a variation based on the GA Certificate. **See page 31** for variation of definition. **Mississippi** has a variation based on the MS Certificate. **See page 34** for variation of definition. **North Carolina** has a variation based on the NC Certificate. **See page 35** for variation of definition.
Mental Illness or Nervous Disorder	Mental Illness or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.
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 to 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. **Tennessee** does not have this definition in the TN Certificate of Insurance.
Optionally Renewable	Optionally Renewable means renewal is at the option of United States Fire Insurance Company.
Outpatient	Outpatient means a Covered Person who receives care in a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Medical Professionals and Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law, without being admitted.

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DEFINITIONS

The definitions below are for all **Group Benefits Fixed Indemnity 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. 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.

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Physician	Physician means a person who is a qualified practitioner of medicine. As such, they must be acting within the scope of their license under the laws in the state in which they practice and providing only those medical services which are within the scope of their license or certificate. It does not include a Covered Person or Covered Person's Immediate Family Member. **Arizona** has a variation based on the AZ Certificate. **See page 29** for variation of definition. **Georgia** has a variation based on the GA Certificate. **See page 32** for variation of definition. **Kentucky** has a variation based on the KY Certificate. **See page 33** for variation of definition. **Tennessee** has a variation based on the TN Certificate. **See page 38** for variation of definition.
Placement for Adoption *(This definition is **ONLY in the NC** Certificate.)*	Placement for Adoption means the assumption and retention by the Insured Person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with the Insured Person terminates upon the termination of such legal obligations
Placement for Foster Home *(This definition is **ONLY in the NC** Certificate.)*	Placement in the Foster Home means physically residing with the Insured Person who has been appointed as guardian or custodian of a Foster Child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the Foster Child with the intent that the Foster Child reside with the guardian or custodian on more than a temporary or short-term basis.
Policyholder	Policyholder means the entity shown as the Policyholder in the Schedule of Benefits.
Pre-Existing Condition	Pre-Existing Condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period before the Covered Person's Effective Date.
Prescription Drug	Prescription Drug means any medication or medicinal substance which has been approved by the U.S. Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a Prescription Order (a legend drug).
Radiology or Radiology Test(s)	Radiology or Radiology Test(s) means the scientific discipline of medical imaging using ionizing radiation, radionuclides, nuclear magnetic resonance, and ultrasound. **Oklahoma** has a variation based on the OK Certificate. **See page 36** for variation of definition.

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DEFINITIONS

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Rural Emergency Hospital *(This definition is **ONLY in the NE** Certificate.)*	Rural Emergency Hospital means a facility that: 1) Meets the statutory eligibility requirements; 2) Provides rural emergency hospital services; 3) Maintains an emergency department to provide rural emergency hospital services in the facility 24 hours per day that is staffed 24 hours per day and 7 days per week, with a physician, nurse practitioner, clinical nurse specialist, or physician assistant; 4) Has a transfer agreement in effect with a comprehensive level trauma center or an advanced level trauma center as defined in the Statewide Trauma System Act and any other transfer agreement necessary for patient care; and 5) Meets such other requirements as needed in the interest of the health and safety of individuals who are provided rural emergency hospital services and to implement licensure under the Health Care Facility Licensure Act that meets requirements for reimbursement by federal health care programs as a Rural Emergency Hospital.
Sickness *(This is the **TX definition only**.)*	Sickness means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person receives medical treatment while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness. Complications of Pregnancy are considered a Sickness.
Sickness *(This is the definition in **all other states** except TX.)*	Sickness means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person receives medical treatment while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.
Skilled Nursing Facility	Skilled Nursing Care Facility means a facility that provides skilled nursing care 24 hours a day, seven days a week, under the supervision of a Medical Professional, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Care Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.
Specialist	Specialist means a Physician who focuses on a specific area of medicine, surgery or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. The Specialist must be acting within the scope of their license, relevant board certifications, and qualifications. It does not include a Covered Person or Covered Person's Immediate Family Member. **Arizona** has a variation based on the AZ Certificate. **See page 29** for variation of definition. **Georgia** has a variation based on the GA Certificate. **See page 32** for variation of definition. **Mississippi** does not have this definition in the MS Certificate of Insurance.

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DEFINITIONS

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP BENEFITS FIXED INDEMNITY INSURANCE	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Spouse	Spouse means lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner. **Georgia** has a variation based on the GA Certificate. **See page 32** for variation of definition.
Substance Abuse	Substance Abuse means the use of any drug or substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.
Surgery or Surgical Procedure	Surgery or Surgical Procedure means the manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life.
Urgent Care Facility *(This is the **TX definition only**.)*	Urgent Care Facility means a free-standing facility, which is engaged primarily in providing minor emergency and episodic medical care on an immediate basis without appointment, other than a Hospital (including any Outpatient department of a Hospital or a Hospital's emergency room), or Medical Professional's office/clinic. It must be licensed as an Urgent Care Facility, if required by law.
Urgent Care Facility *(This is the definition in **all other states** except TX.)*	Urgent Care Facility means a free-standing facility, which is engaged primarily in providing minor emergency and episodic medical care on an immediate basis without appointment, other than a Hospital (including any Outpatient department of a Hospital), Emergency Room, or Medical Professional's office/clinic. It must be licensed as an Urgent Care Facility, if required by law..
We, Our, Us	We, Our, Us means United States Fire Insurance Company underwriting this insurance or its authorized agent.
X-Ray	X-Ray means a form of electromagnetic radiation that passes through structures within the body and results in images of the structures. This definition does not include any Diagnostic Exam or Lab Test.

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STATE VARIATIONS AND ADDITIONS

DEFINITION STATE VARIATIONS- GROUP BENEFITS INDEMNITY INSURANCE

In this section of the agent guide, all of the state variations that are different from the definitions listed between pages 16-27 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

DEFINITION TERM[1]	DEFINITION MEANING[1]
ARIZONA	
Child or Children	Child or Children means the Insured Person's natural child, adopted child (or child placed in the Insured Person's home for purposes of adoption for whom the application and approval procedures for adoption have been completed), foster child, stepchild, or other child for whom the Insured Person has legal guardianship (proof will be required). The coverage for newly born or adopted children or children placed for adoption shall include coverage of Injury or Sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
Dependent	Dependent means an Insured 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 an Insured Person's unmarried Child who is incapable of self-sustaining employment by reason of 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.
Hospital	Hospital means an institution licensed, accredited or certified by the State that: 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons; 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call; 4) Has a staff of one or more licensed Medical Professionals available at all times; 5) Provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities. In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.
Physician	Physician means a person who is a qualified practitioner of medicine. As such, they must be acting within the scope of their license under the laws in the state in which they practice and providing only those medical services which are within the scope of their license or certificate. It does not include a Covered Person.
Specialist	Specialist means a Physician who focuses on a specific area of medicine, surgery or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. The Specialist must be acting within the scope of their license, relevant board certifications, and qualifications. It does not include a Covered Person.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GEORGIA	
Child or Children	Child or Children means the Insured Person's natural child (beginning from the moment of birth), adopted child (beginning from the date the child is placed in the Insured Person's home for purposes of adoption or final decree of adoption, whichever occurs first), foster child, stepchild, or other child for whom the Insured 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; (i) preeclampsia; and (j) 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; • Medical Professional prescribed rest during the period of pregnancy; • Morning sickness; 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 an Insured Person's: 1) lawful Spouse, if not legally divorced; 2) Domestic Partner; 3) unmarried Children **under age 26**. The age limitations will not apply to an Insured Person's unmarried Child who is incapable of self-sustaining employment by reason of 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.
Domestic Partner	Domestic Partner means an opposite or same sex partner who, for at least 6 consecutive months prior to the execution of a Domestic Partner's Registry/Affidavit, has resided with the Insured Person in a single, shared residence.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GEORGIA (continued)	
Experimental or Investigational	Experimental or Investigational means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The procedure will also be considered Experimental or Investigational if the Covered Person is required to sign a consent form that indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, that is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental or Investigational. A drug, device or biological product is considered Experimental or Investigational if it does not have FDA approval or approval under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption.
Hospital	Hospital means an institution licensed, accredited or certified by the State that: 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons; 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call; 4) Has a staff of one or more licensed Medical Professionals available at all times; 5) Provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities. In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; or a nursing home, except as specifically stated.
Immediate Family Member	Immediate Family Member means a Covered Person's Spouse, parent, Child(ren) (includes legally adopted or step child(ren), brother, sister, grandchild(ren), or in-laws.
Medical Professionals	Medical Professional(s) means a person who is a Physician or who is not a Physician but is appropriately licensed to provide some medical care and treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). The Medical Professional must be acting within the scope of their license, relevant board certifications, and qualifications. If required by law, the Medical Professional must be under the supervision of a Physician. A Medical Professional does not include a Covered Person or Covered Person's Immediate Family Member or Domestic Partner. This does not include holistic providers.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GEORGIA (continued	
Physician	Physician means a person who is a qualified practitioner of medicine. As such, they must be acting within the scope of their license under the laws in the state in which they practice and providing only those medical services which are within the scope of their license or certificate. It does not include a Covered Person or Covered Person's Immediate Family Member or Domestic Partner.
Specialist	Specialist means a Physician who focuses on a specific area of medicine, surgery or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. The Specialist must be acting within the scope of their license, relevant board certifications, and qualifications. It does not include a Covered Person or Covered Person's Immediate Family Member or Domestic Partner.
Spouse	Spouse means lawful spouse, if not legally divorced.
KENTUCKY	
Child	Child or Children means the Insured Person's natural child, adopted child (or child placed in the Insured Person's home for purposes of adoption), foster child, stepchild, or other child for whom the Insured Person has legal guardianship (proof will be required).
Dependent	Dependent means an Insured 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 an Insured Person's unmarried Child who is incapable of self-sustaining employment by reason of 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.
Hospital	Hospital means an institution licensed, accredited or certified by the State that: 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons; 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call; 4) Has a staff of one or more licensed Medical Professionals available at all times; 5) Provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities. In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
KENTUCKY (Continued)	
Physician	Physician means a person who is a qualified practitioner of medicine, including an optometrist, osteopath, physician, chiropractor, podiatrist and dentist. As such, they must be acting within the scope of their license under the laws in the state in which they practice and providing only those medical services which are within the scope of their license or certificate. It does not include a Covered Person or Covered Person's Immediate Family Member.
MISSISSIPPI	
Child or Children	Child or Children means the Insured Person's natural child, adopted child (or child placed in the Insured Person's home for purposes of adoption), foster child, stepchild, or other child for whom the Insured Person has legal guardianship (proof will be required).
Dependent	Dependent means an Insured 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 an Insured Person's unmarried Child who is incapable of self-sustaining employment by reason of 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.
Hospital	Hospital means an institution licensed, accredited or certified by the State that: 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons; 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call; 4) Has a staff of one or more licensed Medical Professionals available at all times; 5) Provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities. In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
MISSISSIPPI (continued)	
Medical Professionals	Medical Professional(s) means a person who is a Physician or who is not a Physician but is appropriately licensed to provide some medical care and treatment, including a chiropractor, dentist, optometrist, nurse practitioner (NP/APRN), physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). The Medical Professional must be acting within the scope of their license, relevant board certifications, and qualifications. If required by law, the Medical Professional must be under the supervision of a Physician. A Medical Professional does not include a Covered Person or Covered Person's Immediate Family Member. This does not include holistic providers.
NEBRASKA	
Child	Child or Children means the Insured Person's natural child, adopted child (or child placed in the Insured Person's home for purposes of adoption), foster child, stepchild, or other child for whom the Insured Person has legal guardianship (proof will be required).
Dependent	Dependent means an Insured Person's: 1) lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner; 2) unmarried Children **under age 30**. The age limitations will not apply to an Insured Person's unmarried Child who is incapable of self-sustaining employment by reason of 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.
Hospital	Hospital means an institution licensed, accredited or certified by the State that: 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons; 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call; 4) Has a staff of one or more licensed Medical Professionals available at all times; 5) Provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities. In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated. Hospital also includes a Rural Emergency Hospital.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
NORTH CAROLINA	
Child	Child or Children means the Insured Person's natural child (beginning from the moment of birth), adopted child (beginning from the date of Placement for Adoption), foster child (beginning from the date of Placement in the Foster Home), stepchild, child for whom coverage is required due to an administrative or court order, or other child for whom the Insured Person has legal guardianship (proof will be required).
Dependent	Dependent means an Insured Person's: 1) lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner; 2) unmarried Children **under age 26**. Attainment of such limiting age shall not operate to terminate the coverage of such Child while the Child is and continues to be: (i) incapable of self-sustaining employment by reason of intellectual or physical disability; and (ii) chiefly dependent upon the Insured Person for support and maintenance. Proof of such incapacity and dependency must be furnished to Us by the Insured Person within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us, but not more frequently than annually after the child's attainment of the limiting age.
Hospital	Hospital means an institution licensed, accredited or certified by the State that: 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons; 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call; 4) Has a staff of one or more licensed Medical Professionals available at all times; 5) Provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities. In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.
Medical Professionals	Medical Professional(s) means a person who is a Physician or who is not a Physician but is appropriately licensed to provide some medical care and treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), optometrist, podiatrist, licensed clinical social worker, certified substance abuse counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor or licensed marriage counselor. The Medical Professional must be acting within the scope of their license, relevant board certifications, and qualifications. If required by law, the Medical Professional must be under the supervision of a Physician. A Medical Professional does not include a Covered Person or Covered Person's Immediate Family Member. This does not include holistic providers.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
OKLAHOMA	
Child or Children	Child or Children means the Insured Person's natural child, adopted child, foster child, stepchild, or other child for whom the Insured Person has legal guardianship (proof will be required). A child who is in the Insured Person's custody pursuant to an interlocutory decree issued pursuant to Oklahoma law vesting temporary care of the child with the Insured Person will be considered an adopted child during the pendency of the adoption proceedings, regardless of whether a final decree of adoption is ultimately issued.
Dependent	Dependent means an Insured 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 an Insured Person's unmarried Child who is incapable of self-sustaining employment by reason of 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.
Hospital	Hospital means an institution licensed, accredited or certified by the State that: 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons; 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call; 4) Has a staff of one or more licensed Medical Professionals available at all times; 5) Provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities. In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.
Radiology or Radiology Tests	Radiology or Radiology Test(s) means the scientific discipline of medical imaging using ionizing radiation, radionuclides, nuclear magnetic resonance, and ultrasound. This includes testing such as X-Rays, CT scan, PET Scan, Ultrasound and MRI.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
TENNESSEE	
Child or Children	Child or Children means the Insured Person's natural child, adopted child (or child placed in the Insured Person's home for purposes of adoption), foster child, stepchild, or other child for whom the Insured 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; (i) preeclampsia; and (j) 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; (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible; and (d) Non-Elective Abortion. Non-Elective Abortion means treatment received when a fetus is not viable as well as treatment when the mother's life is endangered. Complications of Pregnancy will not include: • False labor; • Occasional spotting; • Medical Professional prescribed rest during the period of pregnancy; • Morning sickness; 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 an Insured 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 an Insured Person's unmarried Child who is incapable of self-sustaining employment by reason of intellectual or physical disability. 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.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
TENNESSEE CONTINUED	
Hospital	Hospital means an institution licensed, accredited or certified by the State that: 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons; 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call; 4) Has a staff of one or more licensed Medical Professionals available at all times; 5) Provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities. In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.
Physician	Physician means a person who is a qualified practitioner of medicine, including a chiropractor. As such, they must be acting within the scope of their license under the laws in the state in which they practice and providing only those medical services which are within the scope of their license or certificate. It does not include a Covered Person or Covered Person's Immediate Family Member.

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AZ, GA, KY, MS, NC, NE, OK, & TN Pre-existing Conditions Limitation

There is no coverage for a Pre-Existing Condition for a period of the first 6 months after the Covered Person's Effective Date of coverage. This Pre-Existing Condition Limitation only applies to the following Benefits:

Hospital Admission Benefit
Hospital Confinement Benefit
Inpatient Surgery Benefit
Inpatient Surgery Anesthesia Benefit
Outpatient Surgery Benefit
Outpatient Surgery Anesthesia Benefit

This Pre-Existing Condition Limitation does not apply to a newborn or newly adopted Child or Child under petition for adoption under the age of 18 if the Child is enrolled for coverage within 90 Days from the date of birth, or the 60 Day period beginning on the date of adoption or filing of a petitioner for adoption.

TX Pre-Existing Conditions Limitation:

There is no coverage for a Pre-Existing Condition until the earlier of the end of 6 consecutive months beginning on or after the Covered Person's Effective Date of coverage, during which the Covered Person has not received medical advice or treatment in connection with such Pre-Existing Condition. This Pre-Existing Condition Limitation only applies to the following Benefits:

Hospital Admission Benefit
Hospital Confinement Benefit
Inpatient Surgery Benefit
Inpatient Surgery Anesthesia Benefit
Outpatient Surgery Benefit
Outpatient Surgery Anesthesia Benefit

This Pre-Existing Condition Limitation does not apply to a newborn or newly adopted Child or Child under petition for adoption under the age of 18 if the Child is enrolled for coverage within 90 Days from the date of birth, or the 60 Day period beginning on the date of adoption or filing of a petitioner for adoption.

GENERAL EXCLUSIONS

The Policy 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:

Below General Exclusions are based on the TX Certificate of Insurance. Any state variations in the Limitations and Exclusions will shown below that Limitation & Exclusion.

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

   (**OK & TN#1**: Intentional suicide, intentional attempted suicide or intentional self-inflicted Injury while sane or insane.)
2. War or any act of war, declared or undeclared.

   (**NC#2**: War or any act of war, declared or undeclared. However, undeclared war does not include acts of terrorism.)

   (**OK#2**: War or any act of war, declared or undeclared, while serving in the military or an auxiliary unit thereto.)
3. While the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;

   (**OK#3**: While the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps. Upon Our receipt of proof of service, the We will refund any premium paid for this time on a pro-rata basis.)
4. Active participation in a riot or insurrection;

   (**OK#4**: Active intentional participation in a riot or insurrection;)
5. Treatment which arises out of, or in the course of fighting, brawling, assault or battery.

   (**OK#5**: Treatment which arises out of, or in the course of intentional fighting, brawling, assault or battery.)

   (**TN#5**: Treatment which arises out of, or in the course of voluntarily fighting, brawling, assault or battery.)
6. Treatment for Mental Illness or Nervous Disorders, except as specifically provided in the Policy.
7. Treatment for Substance Abuse, except as specifically provided in the Policy.
8. Injury or Sickness caused by, contributed to or resulting from the Covered Person being intoxicated or being under the influence of illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Medical Professional.

   (**GA#8**: 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 being engaged in an illegal occupation.)

   (**NC#8**: Injury or Sickness caused by, contributed to or resulting from the Covered Person being intoxicated or being under the influence of any narcotic unless administered on the advice of the Covered Person's Medical Professional.)

   (**TN#8**: Loss sustained or contracted in consequence of the Covered Person's being Intoxicated or being under the influence of any narcotic unless administered on the advice of a Medical Professional. Intoxicated will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.)
9. 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.

   (**GA#9**: Services or treatment rendered by a Medical Professional or any other person who is employed by the Policyholder; or an Immediate Family Member or Domestic Partner of the Covered Person.)

   (**OK#9**: Intentional 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.)
10. Services or treatment rendered by a Medical Professional or any other person who is employed by the Policyholder; or an Immediate Family Member of the Covered Person. However, this exclusion does not apply to the Dental Indemnity Benefit, if included in the Schedule of Benefits.

    (**AZ #10**: Services or treatment rendered by a Medical Professional or any other person who is employed by the Policyholder)

    (**GA#10**: Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.)

    (**KY, MS, NC, NE #10**: Services or treatment rendered by a Medical Professional or any other person who is employed by the Policyholder; or an Immediate Family Member of the Covered Person.)
11. Travel or activity outside the United States, except for Emergency Care treatment. Participation in any motorized race or speed contest.

    (**AZ, GA, KY, MS, NC, NE, OK & TN#11**: Travel or activity outside the United States, except for treatment of a Medical Emergency.)
12. Participation in any motorized race or speed contest.

    (**OK#12**: Intentional participation in any motorized race or speed contest.)
13. Injury to a Covered Person resulting from that Covered Person's willful violation of the Policyholder's rules or regulations. Willful violation includes, but is not limited to: a) working without protective clothing, helmets, gloves, etc., required by the Policyholder's rules or regulations; or b) participating in any activity that is in violation of the Policyholder's rules or regulations.

    (**KY#13**: Injury to a Covered Person resulting from that Covered Person's willful violation of the Policyholder's rules or regulations. Willful violation includes: a) working without protective clothing, helmets, gloves, etc., required by the Policyholder's rules or regulations; or b) participating in any activity that is in violation of the Policyholder's rules or regulations.)

14. pregnancy, except Complications of Pregnancy, or childbirth unless conception occurred while coverage was in force under the Policy.
15. Elective Abortion. Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

    (**TN#15**: Elective Abortion. Elective Abortion means an abortion for any reason other the fetus is not viable or the mother's life is endangered.)
16. Experimental or Investigational drugs, services, supplies or procedure that is Experimental or Investigational at the time the procedure is done.
17. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
18. Treatment or services provided by a private duty nurse, unless provided for in the Policy.
19. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
20. Dental services, except as specifically provided in the Policy.
21. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in the Policy.
22. 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 myofascial pain, except as specifically provided in the Policy.

    (**NC #22 Omission**: The #22 exclusion listed above is not in the NC Certificate. #22 in NC Certificate skips to #23 below)
23. Treatment for blood or blood plasma;
24. Routine vision care, except as specifically provided in the Policy.
25. 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;
26. Travel in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV);jet ski; ski cycle; snow mobile; or riding in a rodeo according to the Policy provisions; or any off-road motorized vehicle not requiring licensing as a motor vehicle;
27. 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; or

    v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; 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.
28. Rest cures or custodial care;
29. Prescription Drugs unless specifically provided for under the Policy.
30. Elective or cosmetic Surgery, except for reconstructive Surgery on a diseased or injured part of the body;
31. Physiotherapy services.
32. Services related to sterilization, reversal of a vasectomy or tubal ligation; in vitro fertilization and diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered Injury or Sickness.
33. No benefits will be paid for an Injury incurred while working for pay or profit.

    (**KY#33**: No benefits will be paid for an Injury incurred while working for pay or profit if the Covered Person is eligible for benefits under any workers' compensation act or similar law.)

    (**NC#33** which is actually numbered **Exclusion #32 in NC Certificate**: Services or supplies for the treatment of an Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a 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 Workers' Compensation Act. No benefits shall be payable under this Policy for any loss for which the Covered Person claims or files under any workers' compensation, employers' liability, occupational disease or similar law until such claim or filing is approved or denied. Upon approval or denial, We will determine Our liability under the terms or conditions of this Policy. In the event a claim is payable under any workers' compensation, employers' liability, occupational disease or similar law arising out of the same or substantially the same Accident or Injury, the Covered Person must immediately reimburse the Company for all benefits paid in conjunction with that Accident or Injury.)
34. Hang-gliding, parachuting, bungee-cord jumping or flight involving, including boarding or alighting from, an ultralight aircraft.
35. #35 IS **ONLY IN MS CERT**: Providing or reimbursing Gender Transition Procedures for people under age 18.

PROVISIONS

The provisions below are for all Group Benefits Fixed Indemnity 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. 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.

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: An Eligible Person will become insured under the Policy, provided proper premium payment is made on the latest of: (1) The Effective Date of their Certificate; or (2) The day they become eligible, according to the referenced date shown in the Enrollment Form.
Newborn Children Coverage	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.. **North Carolina** has a variation based on the NC Certificate. **See page 63** for variation of provision language.
Newborn Adopted Children Coverage	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.. **North Carolina** has a variation based on the NC Certificate. **See page 63** for variation of provision language.
Newborn Child Exception *(This provision description is for **all states** except TX).*	Newborn Child Exception: This section does not apply to a newborn Child if the Child is born to a Covered Person while insured as a Dependent Child under the Policy. Benefits for newborn Children apply only to a Child born to an Insured Person or their Spouse, Domestic Partner or Civil Union Partner. **Georgia** has a variation based on the GA Certificate. **See page 56** for variation of provision language. **Texas** does not have this provision in the TX Certificate.
Adopted Children Coverage	Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date the Insured Person is a party to a suit in which the Insured Person seeks to adopt the child. A notice of the 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. **Arizona** has a variation based on the AZ Certificate. **See page 55** for variation of provision language. **Georgia** has a variation based on the GA Certificate. **See page 56** for variation of provision language. **Kentucky** has a variation based on the KY Certificate. **See page 57** for variation of provision language. **Mississippi** has a variation based on the MS Certificate. **See page 58** for variation of provision language. **Nebraska** has a variation based on the NE Certificate. **See page 62** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 63** for variation of provision language. **Oklahoma** has a variation based on the OK Certificate. **See page 65** for variation of provision language. **Tennessee** has a variation based on the TN Certificate. **See page 66** for variation of provision language.

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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
Court Ordered Custody	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. **North Carolina** does not have this provision in the NC Certificate.
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 Expiration Date shown in the Policy: or 2) The premium due date if premiums are not paid when due, subject to any Grace Period. 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 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. **Mississippi** has a variation based on the MS Certificate. **See page 58** for variation of provision language. **Oklahoma** has a variation based on the OK Certificate. **See page 65** for variation of provision language.
Insured Person's Termination Date	Insured Person's Termination Date Insurance for an Insured Person will end on the earliest of: 1) The date the Insured Person is no longer in an Eligible Class. 2) The date the Insured Person reports for full-time active duty in any Armed Forces 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 their 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, subject to any Grace Period; or 4) The date the Policy is terminated; or 5) The date the Insured Person requests, in writing, that their coverage be terminated; or 6) The date the membership ends.

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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
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 Insured Person's coverage ends; or 3. The date the Dependent is no longer a Dependent; or 4. The date the Covered Person 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 their Certificate. This does not include Reserve or National Guard duty for training; 5. The last day of the period for which premiums have been paid, subject to any Grace Period.
Extension of Benefits *(This provision is **ONLY** listed in the **TX Certificate**.)*	EXTENSION OF BENEFITS A discontinuation of coverage occurring during a period of Total Disability does not affect any specific indemnity required to be provided under the Policy during a period of Hospital Confinement. Totally Disabled or Total Disability, for purposes of the Extension of Benefits provision, means: 1. with respect to the Insured Person, the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability; and 2. with respect to any other Covered Person, confinement as a bed patient in a Hospital. **Arizona** does not have this provision based on the AZ Certificate. **Georgia** does not have this provision based on the GA Certificate. **Kentucky** does not have this provision based on the KY Certificate. **Mississippi** does not have this provision based on the MS Certificate. **Nebraska** does not have this provision based on the NE Certificate. **North Carolina** does not have this provision based on the NC Certificate. **Oklahoma** does not have this provision based on the OK Certificate. **Tennessee** does not have this provision based on the TN Certificate.

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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 *(This is the **TX provision description only**.)*	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 the Policy with regard to change. 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.
Premiums *(This is the provision description in **all other states** except MS & TX.)*	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 the 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 Grace Period. The Policyholder shall be liable to the Company for the payment of a pro rata premium for the time the Policy was in force during 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. **Mississippi** has a variation based on the MS Certificate. **See page 58** for variation of provision language.
Grace Period *(This is the **TX provision description only**.)*	Grace Period: A Grace Period of 31 days will be allowed for the payment of premium after the first premium. During the Grace Period, the Policy will be in force and We will continue to be liable for valid claims for covered losses 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 the 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.
Grace Period *(This is the provision description in **all other states** except TX.)*	Grace Period: This Certificate has a 31 day Grace Period for the payment of each premium due after the first premium due date. Coverage will stay in force during this Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

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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 *(This is the **TX provision description only**.)*	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 Policyholder's most recent address in Our records. Not less than 60 days before the date on which a premium rate increase takes effect on the Policy, the Company shall give written notice to the Policyholder of the amount of the increase and the date on which the increase is to take effect. The Company shall not require the Policyholder to respond to renew the Policy or take other action relating to the renewal or extension of the Policy before the 45th day after the date such notice of a premium rate increase is given. 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 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. 6) A change in the experience rating.
Changes in Premium Rate *(This is the provision description in **all other states** except KY, MS NC, TN, & TX.)*	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 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 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. 6) A change in the experience rating. **Kentucky** has a variation based on the KY Certificate. **See page 57** for variation of provision language. **Mississippi** has a variation based on the MS Certificate. **See page 58** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 63** for variation of provision language. **Tennessee** has a variation based on the TN Certificate. **See page 66** for variation of provision language.
Reinstatement	Reinstatement The Policy may be reinstated within 14 days of lapse if it is lapsed for nonpayment of premium, if the Policyholder submits written application to the Company, the Company accepts the application and the Policyholder makes payment of all overdue premiums. If an Insured Person's insurance ends for nonpayment of premium, insurance may be reinstated for an Insured Person and their Dependents within 14 days. The following conditions must be met for an Insured Person's insurance to be reinstated: 1. the Policy remains in force; 2. the Insured Person and their Dependents are eligible under the Policy; 3. a written request for reinstatement and a new Enrollment Form are sent to Us; and 4. the required premium is paid. Any benefits paid during the Certificate Period in which the Insured Person's and their Dependents' insurance is reinstated will be applied towards the Benefit Amounts for that Certificate Period. Reinstated insurance will be effective on the date the required premium and new Enrollment Form are received by Us. We will not pay benefits while insurance is not in force under the Policy. **Mississippi** has a variation based on the MS Certificate. **See page 59** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 64** 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
Notice of Claim	NOTICE OF CLAIM: Written notice of claim 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 the Policy 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. **Tennessee** has a variation based on the TN Certificate. **See page 66** for variation of provision language.
Claim Forms *(This is the **TX provision description only**.)*	CLAIM FORMS: We, upon receipt of a written notice of claim, will furnish to the Covered Person such forms as are usually furnished by Us for filing proofs of loss. If forms are not furnished before the 16th day after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements as to proof of loss upon submitting, within the time specified for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.
Claim Forms *(This is the provision description in **all other states** except GA & TX)*	CLAIM FORMS: We, upon receipt of a written notice of claim, will furnish to the Covered Person such forms as are usually furnished by Us for filing proofs of loss. If forms are not furnished within 15 days after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements as to proof of loss upon submitting, within the time specified for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. **Georgia** has a variation based on the GA Certificate. **See page 56** 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 Covered Loss for which the 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 Covered 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. **Georgia** has a variation based on the GA Certificate. **See page 56** for variation of provision language. **North Carolina** has a variation based on the NC Certificate. **See page 64** 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
Notice of Acceptance / Rejection of Claim *(This provision language is **ONLY in the TX** Certificate.)*	NOTICE OF ACCEPTANCE/REJECTION OF CLAIM: We shall notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date We receive all items, statements, and forms required to secure final Proof of Loss.
Time of Payment of Claims *(This is the **TX provision description only**.)*	TIME OF PAYMENT OF CLAIMS: Indemnities payable under the Policy for any loss other than a loss for which the Policy/Certificate provides periodic payments will be paid as they accrue no later than 60 days after Our receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the Policy/Certificate provides periodic payment will be paid no less frequently than monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.
Time of Payment of Claims *(This is the provision description in **all other states** except AZ, GA, MS, OK & TX)*	TIME OF PAYMENT OF CLAIMS: Indemnities payable under the Policy for any loss other than a loss for which the Policy/Certificate provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the Policy/Certificate provides periodic payment will be paid no less frequently than monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof. **Arizona** has a variation based on the AZ Certificate. **See page 55** for variation of provision language. **Georgia** has a variation based on the GA Certificate. **See page 56** for variation of provision language. **Mississippi** has a variation based on the MS Certificate. **See page 60** for variation of provision language. **Oklahoma** has a variation based on the OK Certificate. **See page 65** for variation of provision language.

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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 *(This is the **TX provision description only**.)*	PAYMENT OF CLAIMS: All benefits will be paid to the Covered Person suffering the loss or the Covered Person's assignee. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to their beneficiary as described in the Designation or Change of Beneficiary provision of the Policy. 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. Benefits will be payable to the Texas Health and Human Services Commission if any of the following conditions exist: 1) The Covered Person 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 Insured Person is a parent of a covered Dependent Child and is: a. A possessory conservator of said Child under an order issued by a Texas court or is not entitled to possession or access to said Child; and b. Required by court order or court approved agreement to pay child support; or 3) The Texas Health and Human Services Commission is paying benefits on behalf of the Child 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 covered Dependent Child may be paid on behalf of the Child to a person who is not the Insured Person if an order issued by a court of competent jurisdiction in Texas names such person the managing conservator of the Child. 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 Dependent Child'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 Covered Person where the Covered Person has paid any portion of a medical bill that would be covered under the terms of the Policy. Any payment made in good faith and compliance with Texas regulations regarding payment of benefits for medical services shall fully discharge Us to the extent of such payment.
Payment of Claims *(This is the provision description in **all other states** except MS & TX)*	PAYMENT OF CLAIMS: All 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 their beneficiary as described in the Designation or Change of Beneficiary provision of the Policy. 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. **Mississippi** has a variation based on the MS Certificate. **See page 59** for variation of provision language.

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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. A Covered Person may change their 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 Insured Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Insured Person's estate.
Physical Examination and Autopsy	PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have a Medical Professional of Our choice examine the Covered Person as often as is reasonably necessary. This provision 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. **Mississippi** has a variation based on the MS Certificate. **See page 59** 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 lawful method, which may include the following: 1) A request for lump sum payment of the amount overpaid or paid in error; or 2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error. **Georgia** has a variation based on the GA Certificate. **See page 56** for variation of provision language. **Oklahoma** has a variation based on the OK Certificate. **See page 66** for variation of provision language. **Tennessee** has a variation based on the TN Certificate. **See page 67** 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
Subrogation	SUBROGATION: If We have paid medical or surgical benefits under the Policy to or on behalf of the Covered Person as a result of a personal Injury to the Covered Person caused by the tortious conduct of a third party, We shall be subrogated to and have a right of reimbursement for benefit payments made from the Covered Person's recovery for that Injury, subject to this provision. If the Covered Person is not represented by an attorney in obtaining a recovery, Our recovery is limited to the lesser of: (a) one-half of the Covered Person's gross recovery; or (b) the total cost of benefits paid by Us as a direct result of the tortious conduct of the third party. If the Covered Person is represented by an attorney in obtaining a recovery, Our recovery is limited to the lesser of: (a) one-half of the Covered Person's gross recovery less attorney's fees and procurement costs; or (b) the total cost of benefits paid by Us as a direct result of the tortious conduct of the third party less attorney's fees and procurement costs. We may not pursue a recovery against the Covered Person's first-party recovery. We may pursue recovery against uninsured/underinsured motorist coverage or medical payments coverage only if the Covered Person or their Immediate Family Member did not pay the premiums for the coverage. Attorney's fees shall be apportioned as follows: (a) Except as provided by item (c), if Our interest is not actively represented by an attorney in an action to recover for a personal Injury to the Covered Person shall pay to an attorney representing the Covered Person a fee in an amount determined under an agreement entered into between the attorney and Us plus a pro rata share of expenses incurred in connection with the recovery. (b) Except as provided by item (c), in the absence of an agreement described by item (a), the court shall award to the attorney, payable out of Our share of the total gross recovery, a reasonable fee for recovery of Our share, not to exceed one-third of the Our recovery. (c) If an attorney representing Our interest actively participates in obtaining a recovery, the court shall award and apportion between the Covered Person's and Our attorneys a fee payable out of Our subrogation recovery. In apportioning the award, the court shall consider the benefit accruing to Us as a result of each attorney's service. The total attorney's fees may not exceed one-third of Our recovery. **Arizona** does not have this provision based on the AZ Certificate. **Georgia** has a variation based on the GA Certificate. **See page 56** for variation of provision language **Kentucky** has a variation based on the KY Certificate. **See page 57** for variation of provision language. **Mississippi** has a variation based on the MS Certificate. **See page 61** for variation of provision language. **Nebraska** has a variation based on the NE Certificate. **See page 62** for variation of provision language. **North Carolina** does not have this provision based on the NC Certificate. **Tennessee** has a variation based on the TN Certificate. **See page 67** for variation of provision language.
Legal Actions	LEGAL ACTIONS: All Policy terms will be interpreted under the laws of the state in which the Policy was issued. No legal action may be brought to recover on the Policy 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.

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PROVISIONS

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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, the Master Application of the Policyholder (a copy of which is attached to the Policy), endorsements, riders, and attached papers, including this Certificate, constitute the entire contract between the parties. If an Enrollment Form for a Covered Person is required, We may also make it a part of this contract. No change in the Policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.
Incontestability *(This provision language is **ONLY in the TX** Certificate.)*	INCONTESTABILITY: We will not contest the Policy after it has been in force for 2 years from its effective date, except for non-payment of premiums. In the absence of fraud, a statement made by any individual covered by the Policy relating to the individual's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made: 1. After the insurance has been in force before the contest for two years during the individual's lifetime; and 2. Unless the statement is contained in a written instrument signed by the individual making the statement. In the absence of fraud, a statement made by the Policyholder or a Covered Person is considered a representation and not a warranty. A statement made by the Policyholder or a Covered Person may not be used in any contest under the Policy, unless a copy of the written instrument containing the statement is or has been provided to: 1. The person making the statement; or 2. If the statement was made by the Covered Person and the Covered Person has died or become incapacitated, the Covered Person's beneficiary or personal representative.
Representations and Not Warranties *(This is the provision description in **all other states** except it is **not** a provision in NC & TX Certificates.)*	REPRESENTATIONS AND NOT WARRANTIES: 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 their death or incapacity, their beneficiary or representative. After two 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.
Time Limit on Certain Defenses *(This provision language is **ONLY in the NC** Certificate.)*	TIME LIMIT ON CERTAIN DEFENSES: 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 their death or incapacity, their beneficiary or representative. After two years from the Covered Person's effective date of coverage, no such statement, except with respect to eligibility for coverage, will cause such coverage to be contested.
Worker's Compensation Insurance	WORKERS' COMPENSATION INSURANCE: The Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.
Policy Termination	POLICY TERMINATION: We may terminate coverage on or after any premium due date. The Policyholder may terminate its coverage on any premium due date. If either party terminates, written notice must be given to the other party at least 60 days prior to such premium due date.

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PROVISIONS

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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 *(This is the **TX provision description only**.)*	CONFORMITY WITH STATE STATUTES: Any provision of the Policy in conflict on its Effective Date with the laws of the State of Texas is amended to conform to the minimum requirements of such laws.
Conformity with State Statutes *(This is the provision description in **all other states** except MS, NE & TX)*	CONFORMITY WITH STATE STATUTES: Any provision of the Policy in conflict on its Effective Date with the laws of the State of Issue indicated on the front page of the Policy is amended to conform to the minimum requirements of such laws. **Mississippi** has a variation based on the MS Certificate. **See page 61** for variation of provision language. **Nebraska** has a variation based on the NE Certificate. **See page 62** for variation of provision language.
*(This provision language is **ONLY in the KY** Certificate.)*	OTHER COVERAGE WITH US: If the Covered Person is covered under one or more of the same type of plan underwritten by Us or Our affiliates and if the Covered Person suffers a loss for which one or more benefits are payable under more than one same type of plan, the maximum amount payable under all of the benefits combined will not exceed the amount payable for one of those losses, the largest, subject to the maximum amount payable under such plan with the largest maximum. Benefit payments will be payable under only one plan.
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. **Mississippi** has a variation based on the MS Certificate. **See page 61** 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.
Non-Participating	NON-PARTICIPATING: The Policy 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 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.
New Entrants	NEW ENTRANTS: To the group originally insured may be added from time to time eligible new persons or Dependents, as the case may be, in accordance with the terms of the Policy
Complaints and Grievances *(This provision language is **ONLY in the AZ** Certificate.)*	COMPLAINTS AND GRIEVANCES: If a Covered Person has a complaint regarding this plan, they may contact customer service representatives at the telephone number indicated on their I.D. Card. The representative will attempt to informally resolve the complaint. Any person submitting a formal written complaint will receive a written reply explaining in detail the resolution and additional levels through which a complaint may be appealed. The written procedure for complaints is available to a Covered Person upon their request.
Misstatement of Age *(This provision language is **ONLY in the MS** Certificate.)*	MISSTATEMENT OF AGE: If premiums and/or benefits for the Covered Person are based on age and the Covered Person's age has been misstated, there will be a fair adjustment of benefits based on the Covered Person's true age. The Company may require satisfactory proof of age before paying any claim.
Certificates *(This provision language is **ONLY in the NC** Certificate.)*	CERTIFICATES: 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 Policy. It will state to whom the benefits will be paid. If made available electronically, Covered Persons may also request a paper Certificate from Us by calling 866-438-4274.

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STATE VARIATIONS AND ADDITIONS

PROVISION VARIATIONS - GROUP BENEFITS INDEMNITY INSURANCE

In this section of the agent guide, all of the state variations that are different from the provisions listed between pages 42-53 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

PROVISION[2]	PROVISION DESCRIPTION[2]
ARIZONA	
EFFECTIVE DATES OF INSURANCE	
Adopted Children Coverage	Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, for whom the application and approval procedures for adoption have been completed, 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.
CLAIMS PROVISIONS	
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Indemnities payable under the Policy for any loss other than a loss for which the Policy/Certificate provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the Policy/Certificate provides periodic payment will be paid no less frequently than monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof. We shall pay the approved portion of any Clean Claim within 30 days after the claim is adjudicated. If the claim is not paid within the 30-day period, We shall pay interest on the claim at a rate that is equal to the legal rate. Interest shall be calculated beginning on the date that the payment to the claimant is due. If the claim is not a Clean Claim and We require additional information to adjudicate the claim, We shall send a written request for additional information to the claimant within 30 days after We receive the claim. We shall notify the claimant of all of the specific reasons for the delay in adjudicating the claim. We shall record the date We receive the additional information and shall adjudicate the claim within 30 days after receiving all the additional information. We shall also pay the approved portion of the adjudicated claim within the same 30- day period allowed for adjudication. If We fail to pay the claim as prescribed in this provision, We shall pay interest on the claim in the manner prescribed above. "Adjudicate" means Our decision to deny or pay a claim, in whole or in part, including the decision as to how much to pay. "Clean claim" means a written or electronic claim for health care services or benefits that may be processed without obtaining additional information, including coordination of benefits information, from the health care provider, the Covered Person or a third party, except in cases of fraud.

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PROVISION[2]	PROVISION DESCRIPTION[2]
GEORGIA	
EFFECTIVE DATES OF INSURANCE	
Newborn Child Exception	Newborn Child Exception: This section does not apply to a newborn Child if the Child is born to a Covered Person while insured as a Dependent Child under the Policy. Benefits for newborn Children apply only to a Child born to an Insured Person or their Spouse or Domestic Partner.
Adopted Children Coverage	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 or final decree of adoption, whichever occurs first. 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.
CLAIMS PROVISIONS	
Claims Forms	CLAIM FORMS: We, upon receipt of a written notice of claim, will furnish to the Covered Person such forms as are usually furnished by Us for filing proofs of loss. If forms are not furnished before the expiration of 10 working days after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements as to proof of loss upon submitting, within the time specified 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 Covered Loss for which the 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 Covered 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.
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Indemnities payable under the Policy for any loss other than a loss for which the Policy/Certificate provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. We shall, within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt, mail or send electronically to the person claiming payments under the Policy, payment for such benefits or a letter or electronic notice which states the reasons for failing to pay the claim, in whole or in part, and which also gives the person so notified a written itemization of any documents or other 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 listed documents or other information needed to process the claim has been received by Us, We shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the person claiming payments under the Policy, Our reasons for such denial. We shall pay interest equal to 12% per annum on the benefits due for failure to comply with this provision. Subject to due written proof of loss, all accrued indemnity for loss for which the Policy/Certificate provides periodic payment will be paid no less frequently than monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.
Right of Recovery / Subrogation	RIGHT OF RECOVERY / SUBROGATION: If the Covered Person has a claim for damages from a third party or parties for any Sickness or Injury for which benefits are payable under the Policy, 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 treatment under the Policy, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Our right of recovery may include compromise settlements. The Covered Person or their attorney must inform Us of any legal action or settlement agreement at least ten days prior to settlement or trial. We will then notify the Covered Person of the amount We seek to recover for covered benefits paid. Our recovery may be reduced by the pro-rata share of the Covered Person's attorney's fees and expenses of litigation.

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PROVISION[2]	PROVISION DESCRIPTION[2]
KENTUCKY	
EFFECTIVE DATES OF INSURANCE	
Adopted Children Coverage	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.
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 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. 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 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. 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	
Subrogation	SUBROGATION: If We have made a payment for a loss under the Policy, and a Covered Person has a right to recover damages from a third party responsible for the loss, We have the right to pursue a refund or recovery even if such Covered Person does not do so. This is called subrogation. When We exercise our right of subrogation, We will be assigned the rights and remedies the Covered Person had relating to the loss. Our right of subrogation applies even if the Covered Person's entire loss has not been compensated. A Covered Person must help Us preserve Our right of subrogation against those responsible for the loss. This may involve signing papers and taking any other steps We may reasonably require. A Covered Person shall help Us exercise Our rights in any reasonable way that We may request. A Covered Person shall not do anything after the loss to prejudice Our rights. 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.

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PROVISION[2]	PROVISION DESCRIPTION[2]
MISSISSIPPI	
EFFECTIVE DATE OF INSURANCE	
Adopted Children Coverage	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.
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 Expiration 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 the Policy at the end of the Grace Period. The Policyholder shall be liable to the Company for the payment of a pro rata premium for the time the Policy was in force during the Grace Period. 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 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.
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 the 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 Grace Period. The Policyholder shall be liable to the Company for the payment of a pro rata premium for the time the Policy was in force during 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. Upon the payment of a claim under the Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.
Changes in Premium Rate	Changes in Premium Rate: The Company may change the premium rates from time to time with at least 75 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 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. 6) A change in the experience rating.

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PROVISION[2]	PROVISION DESCRIPTION[2]
MISSISSIPPI (continued)	
PREMIUM PROVISIONS (continued)	
Reinstatement	Reinstatement If any renewal premium be not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. However, if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the Policyholder in writing of Our disapproval of such application. 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 Sickness as may begin more than ten (10) days after such date. In all other respects the Policyholder and Us shall have the same rights thereunder as the parties 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 sixty (60) days prior to the date of reinstatement.
CLAIMS PROVISIONS	
Payment of Claims	PAYMENT OF CLAIMS: All 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 their beneficiary as described in the Designation or Change of Beneficiary provision of the Policy. 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. When payments of benefits are made to the Covered Person directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. If the Covered Person provides Us with written direction that all or a portion of any indemnities or benefits provided by the Policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then We shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the Covered Person any amount above that payment, other than the Deductible, Coinsurance, Copayment or other charges for equipment or services requested by the Covered Person that are noncovered benefits. Any dispute between a provider and the Covered Person arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance.
Physical Examination	PHYSICAL EXAMINATION: We have the right to have a Medical Professional of Our choice examine the Covered Person as often as is reasonably necessary. This provision applies when a claim is pending or while benefits are being paid. We will pay the cost of the examination.

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PROVISION[2]	PROVISION DESCRIPTION[2]
MISSISSIPPI (continued)	
CLAIMS PROVISIONS	
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: All benefits payable under the Policy for any loss, other than loss for which the Policy provides any periodic payment, will be paid within 25 days after receipt of due written proof of such loss in the form of a Clean Claim where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of such loss in the form of a Clean Claim where claims are submitted in paper format. Benefits due under the Policy and claims are overdue if not paid within 25 days or 35 days, whichever is applicable, after We receive a Clean Claim containing necessary medical information and other information essential for Us to administer Pre-existing Condition and Subrogation provisions. 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. Errors, such as system errors, attributable to Us, do not change the Clean Claim status. 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 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 Pre-existing Condition or Subrogation provisions; or (d) Claims submitted by a provider more than 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 30 days after the date of billing by the provider to the Covered Person. Not later than 25 days after the date We actually receive an electronic claim, We shall pay the appropriate benefit in full or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 35 days after the date We actually receive a paper claim, We shall pay the appropriate benefit in full or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by Us shall be paid within 20 days after receipt. For purposes of this provision, the term "pay" means that We shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or the Covered Person. Subject to due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid within 30 days after receipt of due written proof. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed above, We shall pay the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) interest on accrued benefits at the rate of 3% per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than $1.00, such amount shall be credited to the account of the person or entity to whom such amount is owed. In the event We fail to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided above and any other damages as may be allowable by law. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or Covered Person) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Upon request, We shall provide to the Covered Person or the provider submitting a claim a written list of the information required and the documentation required for Us to deem a claim to be clean, and We shall then be bound to such list.

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PROVISION[2]	PROVISION DESCRIPTION[2]
MISSISSIPPI (continued)	
CLAIMS PROVISIONS	
Subrogation	SUBROGATION: If We have made a payment for a loss under the Policy, and a Covered Person has a right to recover damages from a third party responsible for the loss, We have the right to pursue a refund or recovery even if such Covered Person does not do so. This is called subrogation. When We exercise our right of subrogation, We will be assigned the rights and remedies the Covered Person had relating to the loss. This Subrogation provision shall not apply until the Covered Person is first made whole for his or her loss. A Covered Person must help Us preserve Our right of subrogation against those responsible for the loss. This may involve signing papers and taking any other steps We may reasonably require. A Covered Person shall help Us exercise Our rights in any reasonable way that We may request. A Covered Person shall not do anything after the loss to prejudice Our rights. 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.
GENERAL PROVISIONS	
Conformity with State Statutes	CONFORMITY WITH STATE STATUTES: Any provision of the Policy in conflict on its Effective Date with the statutes of the jurisdiction in which the Insured Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.
Assignment	ASSIGNMENT: This coverage may not be assigned. However, benefit payments may be assigned at the time of claim. Any payment made by the Company in good faith will end Our liability to the extent of the payment.

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PROVISION[2]	PROVISION DESCRIPTION[2]
NEBRASKA	
EFFECTIVE DATE OF INSURANCE	
Adopted Children Coverage	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.
CLAIMS PROVISIONS	
Subrogation	SUBROGATION: If We have made a payment for a loss under the Policy, and a Covered Person has a right to recover damages from a third party responsible for the loss, We have the right to pursue a refund or recovery even if such Covered Person does not do so. This is called subrogation. When We exercise our right of subrogation, We will be assigned the rights and remedies the Covered Person had relating to the loss. A Covered Person must help Us preserve Our right of subrogation against those responsible for the loss. This may involve signing papers and taking any other steps We may reasonably require. A Covered Person shall help Us exercise Our rights in any reasonable way that We may request. A Covered Person shall not do anything after the loss to prejudice Our rights. 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.
GENERAL PROVISIONS	
Conformity with State and Federal Law	CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of the Policy which, on its Effective Date, is in conflict with the law of the federal government or the state in which the Insured Person resides on such date is hereby amended to conform to the minimum requirements of such law.

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PROVISION[2]	PROVISION DESCRIPTION[2]
NORTH CAROLINA	
EFFECTIVE DATE OF INSURANCE	
Newborn Child coverage	Newborn Children Coverage: We will provide coverage for a newborn Child from the moment of birth. If additional premium is required, 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. Notice is not required if no additional premium will be required when the Child is added, but the Insured Person should complete a status change form so that We may send an identification card to facilitate the Child's access to covered benefits.
Newborn Adopted Child Coverage	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. If additional premium is required, 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. Notice is not required if no additional premium will be required when the Child is added, but the Insured Person should complete a status change form so that We may send an identification card to facilitate the Child's access to covered benefits.
Adopted Children Coverage	Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of Placement for Adoption in the Insured Person's home. If additional premium is required, 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. Notice is not required if no additional premium will be required when the Child is added, but the Insured Person should complete a status change form so that We may send an identification card to facilitate the Child's access to covered benefits.
PREMIUM PROVISIONS	
Changes in Premium Rate	Changes in Premium Rate: The Company may change the premium rates after the first 12-month Policy Term with at least 60 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 every 6-month period thereafter, based on 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 the 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 the Policy. 6) A change in the experience rating, based on at least 12 months of experience.

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PROVISION[2]	PROVISION DESCRIPTION[2]
NORTH CAROLINA (continued)	
PREMIUM PROVISIONS (continued)	
Reinstatement	Reinstatement If any renewal premium be not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us, or, lacking such approval, upon the 45th day following the date of such conditional receipt unless We have previously notified the Policyholder in writing of Our disapproval of such application. 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 Sickness as may begin more than 10 days after such date. In all other respects the Policyholder and Us shall have the same rights thereunder 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. If an Insured Person's insurance ends for nonpayment of premium, insurance may be reinstated for an Insured Person and their Dependents within 14 days. The following conditions must be met for an Insured Person's insurance to be reinstated: 1. the Policy remains in force; 2. the Insured Person and their Dependents are eligible under the Policy; 3. a written request for reinstatement and a new Enrollment Form are sent to Us; and 4. the required premium is paid. Any benefits paid during the Certificate Period in which the Insured Person's and their Dependents' insurance is reinstated will be applied towards the Benefit Amounts for that Certificate Period. Reinstated insurance will be effective on date the required premium and new Enrollment
CLAIMS PROVISIONS	
Proof of Loss	PROOF OF LOSS: Written proof of loss must be furnished to Us in the case of a claim for Covered Loss for which the Policy 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 Covered 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]
OKLAHOMA	
EFFECTIVE DATE OF INSURANCE	
Adopted Children Coverage	Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from he date of placement in the Insured Person's custody pursuant to an interlocutory decree issued pursuant to Oklahoma law vesting temporary care of the Child with the Insured Person. Such Child will be considered an adopted Child during the pendency of the adoption proceedings, regardless of whether a final decree of 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 at the expiration of the initial 31 day period.
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 Expiration Date shown in the Policy; 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 the Policy at the end of the Grace Period. The Policyholder shall be liable to the Company for the payment of a pro rata premium for the time the Policy was in force during the Grace Period. 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 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.
CLAIMS PROVISIONS	
Time of Payment of Claims	TIME OF PAYMENT OF CLAIMS: Indemnities payable under the Policy for any loss other than a loss for which the Policy/Certificate provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the Policy/Certificate provides periodic payment will be paid no less frequently than monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof. We will pay all Clean Claims of a Covered Person, their assignee or a health care provider within 45 calendar days after receipt of the claim by Us. "Clean Claim" means a claim for benefits that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that impedes prompt payment. If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment We will notify the Covered Person, their assignee or health care provider in writing within 30 calendar days after We receive the claim. Our written notice will state the portion of the claim that is causing the delay in processing and explain any additional information or corrections needed. Failure to provide this notice will constitute prima facie evidence that the claim will be paid in accordance with the terms of the Policy. Upon receipt of the additional information or corrections which led to the claim being delayed and a determination that the information is accurate, We will either pay or deny the claim or a portion of the claim within 45 calendar days. Payment is considered made on the date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the U.S. mail in a properly addressed, postpaid envelope; or if not so posted, the date of delivery. An overdue payment will bear simple interest at the rate of 10% per year.

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PROVISION[2]	PROVISION DESCRIPTION[2]
OKLAHOMA (continued	
CLAIMS PROVISIONS (continued)	
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 lawful method within 12 months after such payment is made, which may include the following: 1) A request for lump sum payment of the amount overpaid or paid in error; or 2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error. However, the 12-month limitation shall not apply: 1) if the payment was made because of fraud committed by the claimant, or 2) if the claimant has otherwise agreed to make a refund to Us for overpayment of a claim.
TENNESSEE	
EFFECTIVE DATE OF INSURANCE	
Adopted Children Coverage	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.
PREMIUM PROVISION	
Changes in Premium Rates	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 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 twice 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 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.
CLAIMS PROVISIONS	
Notice of Claims	NOTICE OF CLAIM: Written notice of claim must be given to Us within 90 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 the Policy Number and a Covered Person's name and address. If written notice is not received 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.

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PROVISION[2]	PROVISION DESCRIPTION[2]
TENNESSEE (continued)	
CLAIMS PROVISIONS (continued)	
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 the Policy by the amount overpaid or paid in error. We must make the request or reduction within 15 months of the date We paid the claim. However, this 15 month time limit shall not apply if the Covered Person does not provide complete information, was not eligible for coverage or material misstatements or fraud have occurred.
Subrogation	SUBROGATION: If We have made a payment for a loss under the Policy, and a Covered Person has a right to recover damages from a third party responsible for the loss, We have the right to pursue a refund or recovery even if such Covered Person does not do so. This is called subrogation. When We exercise our right of subrogation, We will be assigned the rights and remedies the Covered Person had relating to the loss. A Covered Person must help Us preserve Our right of subrogation against those responsible for the loss. This may involve signing papers and taking any other steps We may reasonably require. A Covered Person shall help Us exercise Our rights in any reasonable way that We may request. A Covered Person shall not do anything after the loss to prejudice Our rights. 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.

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CRITICAL ILLNESS BENEFIT RIDER

CRITICAL ILLNESS BENEFIT

We will pay the percentage of the Critical Illness Benefit Amount, shown in the Rider Schedule of Benefits, if the Covered Person is First Diagnosed with a Critical Illness Covered Condition listed in the Rider Schedule of Benefits after their effective date of coverage under this Rider and after the Critical Illness Benefit Waiting Period shown in the Rider Schedule of Benefits.

The Covered Person must be covered continuously under the Policy and this Rider before the Critical Illness Benefit Amount may be payable and the Critical Illness Covered Condition must first occur after the Critical Illness Benefit Waiting Period. If the Covered Person's condition is First Diagnosed during the Critical Illness Benefit Waiting Period, no benefits will be payable, this Rider will terminate for such Covered Person, and We will refund to the Covered Person all premiums paid for this Rider without interest.

The Critical Illness Benefit is only paid once per Covered Person's lifetime. After the payment is made to the Covered Person, this Critical Illness Benefit will terminate for such Covered Person.

The Critical Illness Benefit Amount is not payable for conditions other than the Critical Illness Covered Conditions shown in the Rider Schedule of Benefits.

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DEFINITIONS

The definitions below are for all **Critical Illness Rider** of the Group Benefits Fixed Indemnity 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. 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.

DEFINITION TERM[1]	DEFINITION MEANING[1]
CRITICAL ILLNESS RIDER	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Benign Brain Tumor	Benign Brain Tumor means a brain tumor that is not a malignant, recurrent, or progressive tumor as confirmed by the examination of tissue (biopsy or surgical excision), MRI, magnetic resonance spectroscopy (MRS), or CT. The brain tumor must result in neurological deficit(s), including but not limited, vision or hearing impairments; seizures; facial paralysis; numb extremities; changes in concentration, memory, or speech; or balance disruption. For purposes of this Rider, the following do not meet the definition of Benign Brain Tumor: • tumors of the skull; • angiomas or aneurysms • pituitary adenomas; and • germinomas. We will not pay the benefit for Benign Brain Tumor if the Covered Person is Diagnosed prior to their effective date of coverage under this Rider with any of the following conditions: • neurofibromatosis I; • neurofibromatosis II; • von Hippel-Lindau; • tuberous sclerosis; • Li-Fraumani syndrome; • cowden disease; and • turcot syndrome.
Benign Brain Tumor Date of Diagnosis	Benign Brain Tumor Date of Diagnosis is the date of the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
Bone Marrow / Stem Cell Transplant	Bone Marrow/Stem Cell Transplant means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells due to an aplastic anemia, congenital neutropenia, severe immunodeficiency syndromes, sickle cell anemia, thalassemia, Fanconi anemia, leukemia, lymphoma, or multiple myeloma.
Bone Marrow / Stem Cell Transplant Date of Diagnosis	Bone Marrow/Stem Cell Transplant Date of Diagnosis is determined by the date of date of onset for medical condition the transplant is associated with, which must be a Covered Loss.
Coma	Coma means a continuous state of profound unconsciousness requiring intubation for respiratory assistance as the result of a severe traumatic brain injury lasting for a period of 7 or more consecutive days, characterized by the absence of: • eye opening; • verbal response; and • motor response. For purposes of this Rider, the following do not meet the definition of Coma: • coma due to stroke; and • any medically induced coma.
Coma Date of Diagnosis	Coma Date of Diagnosis is the date a Medical Professional confirms a Coma.

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DEFINITIONS

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DEFINITION TERM[1]	DEFINITION MEANING[1]
CRITICAL ILLNESS RIDER	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Coronary Artery Disease	Coronary Artery Disease means a narrowing or blockage of one or more coronary arteries resulting from plaque buildup. • Coronary Artery Bypass means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, performed by a Medical Professional who is a board-certified cardiothoracic surgeon. • Coronary Artery Angioplasty means a procedure used to open clogged heart arteries by utilizing a balloon catheter inserted in a blocked blood vessel to help widen it, performed by a Medical Professional who is a board-certified cardiothoracic surgeon.
Coronary Artery Disease Date of Diagnosis	Coronary Artery Disease Date of Diagnosis is the date a cardiologist recommends a covered person undergo a surgical procedure of either a coronary artery bypass graft or valve replacement.
Date of Diagnosis	Date of Diagnosis means the date a Medical Professional confirms, or a test proves, that a Critical Illness Covered Condition exists. Date of Diagnosis requirements vary by Covered Condition, and are specified in this Definitions section.
Diagnosis or Diagnosed	Diagnosis or Diagnosed means a written diagnosis by a Medical Professional of the Covered Person's Critical Illness Covered Condition.
Diplegia	Diplegia means complete and irreversible loss of all motion and all practical use of both arms or both legs as determined by a Medical Professional.
End Stage Renal (Kidney) Failure	End Stage Renal (Kidney) Failure means chronic irreversible failure of the function of both kidneys such that the Covered Person must undergo at least weekly hemodialysis or peritoneal dialysis.
End Stage Renal (Kidney) Failure Date of Diagnosis	End Stage Renal (Kidney) Failure Date of Diagnosis means the date that a Medical Professional recommends regular hemodialysis or peritoneal dialysis to sustain life; the Covered Person has a kidney transplant performed; or the Covered Person is placed on the UNOS (United Network for Organ Sharing) list for a kidney transplant.
First Diagnosis	First Diagnosis means the first time a Medical Professional Diagnoses a Covered Person as having a Critical Illness Covered Condition, which has been clinically or pathologically Diagnosed by a Medical Professional after the Critical Illness Benefit Waiting Period and while their coverage under this Rider is in force.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Critical Illness Rider of the Group Benefits Fixed Indemnity 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.

DEFINITIONS

The definitions below are for all **Critical Illness Rider** of the Group Benefits Fixed Indemnity 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. 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.

DEFINITION TERM[1]	DEFINITION MEANING[1]
CRITICAL ILLNESS RIDER	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Heart Attack (Myocardial Infarction)	Heart Attack (Myocardial Infarction) means the ischemic death of a portion of heart muscle (myocardium) as a result of obstruction of one or more of the coronary arteries. A positive Diagnosis of myocardial infarction must occur and must be supported by three or more of the following: • chest pain; • electrocardiographic (EKG) changes indicative of myocardial infarction; in the case of myocardial infarction associated with percutaneous coronary intervention (balloon angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria in establishing a diagnosis; • elevation of biochemical markers of myocardial necrosis; and • confirmatory imaging studies. In the event of death, an autopsy, medical examiner's confirmation, or death certificate identifying Heart Attack (Myocardial Infarction) as the cause of death will be accepted. The following are not to be construed as a Heart Attack (Myocardial Infarction) for purposes of this Rider: • an established (old) heart attack; • angina; • atherosclerotic heart disease; • cardiac arrest (including arrhythmias); • congestive heart failure; • coronary artery disease; and • any other disease, injury, or dysfunction of the cardiovascular system.
Heart Attack (Myocardial Infarction) Date of Diagnosis	Heart Attack (Myocardial Infarction) Date of Diagnosis is the date the ischemic death of a portion of the heart muscle (myocardium) occurred based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
Hemiplegia	Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body as determined by a Medical Professional.
Invasive Cancer	Invasive Cancer means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells and must be Diagnosed in one of two ways: 1. Clinical Diagnosis: A Clinical Diagnosis of Invasive Cancer is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if: a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; b. there is medical evidence to support the Diagnosis; and c. a Medical Professional is treating the Covered Person for Invasive Cancer. 2. Pathological Diagnosis: A Pathological Diagnosis of Invasive Cancer made by a pathologist is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy Diagnosis must be in accordance with the standards established by the American Board of Pathology. A Pathological Diagnosis of Invasive Cancer can be made before or after death. The following are not to be construed as Invasive Cancer for purposes of this Rider: • pre-malignant conditions or conditions with malignant potential; • cancer that has not become invasive, typically classified as stage 0 or in situ; • cancer on the surface of the body (skin) that may be: - melanomas that are in situ, stage 0, stage 1, or stage 2; - basal cell carcinoma; or - squamous cell carcinoma of the skin; and • a flare-up, spread or metastasis of a cancer (invasive) that the Covered Person was First Diagnosed with before their effective date of coverage under this Rider.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Critical Illness Rider of the Group Benefits Fixed Indemnity 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.

DEFINITIONS

The definitions below are for all **Critical Illness Rider** of the Group Benefits Fixed Indemnity 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. 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.

DEFINITION TERM[1]	DEFINITION MEANING[1]
CRITICAL ILLNESS RIDER	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Invasive Cancer Date of Diagnosis	Invasive Cancer Date of Diagnosis means the date the tissue specimen, blood samples or titer(s) are taken upon which the Diagnosis of Invasive Cancer or Non-Invasive Cancer is based.
Major Organ Failure Requiring Transplant	Major Organ Failure Requiring Transplant means failure of the heart, kidney, liver, both lungs, or pancreas resulting in the Covered Person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.
Major Organ Failure Requiring Transplant Date of Diagnosis	Major Organ Failure Requiring Transplant Date of Diagnosis is the date that the Covered Person is placed on the UNOS list for transplantation.
Non-Invasive Cancer	Non-Invasive Cancer means a malignant tumor which is typically classified as stage 0 or in situ, that has not yet become invasive but is confined to the site of origin without having invaded neighboring tissue. For purposes of this Rider, the following do not meet the definition of Non-Invasive Cancer: • pre-malignant conditions or conditions with malignant potential; and • cancer on the surface of the body (skin) that may be: - melanomas that are in situ, stage 0, or stage 1; - basal cell carcinoma; or - squamous cell carcinoma of the skin.
Non-Invasive Cancer Date of Diagnosis	Non-Invasive Cancer Date of Diagnosis means the date the tissue specimen, blood samples or titer(s) are taken upon which the Diagnosis of Invasive Cancer or Non-Invasive Cancer is based.
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D means Diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B, C or D contaminated fluids as the result of a Covered Accident during the normal course of performing an occupation for which remuneration is earned. We will pay this benefit if: • within five days of the Covered Accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the Covered Person's occupation or profession; • the Covered Accident is investigated and a written investigation report is provided to Us by the Covered Person's employer; • a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the Covered Accident and HIV or Hepatitis B, C or D is not present; • all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and • a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the Covered Accident, and the result is positive. Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D excludes: • HIV or Hepatitis B, C or D infection as the result of IV drug use; • HIV or Hepatitis B, C or D infection as the result of sexual transmission; and • HIV or Hepatitis B, C or D infection determined not to have been the result of a Covered Accident.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Critical Illness Rider of the Group Benefits Fixed Indemnity 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.

DEFINITIONS

The definitions below are for all **Critical Illness Rider** of the Group Benefits Fixed Indemnity 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. 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.

DEFINITION TERM[1]	DEFINITION MEANING[1]
CRITICAL ILLNESS RIDER	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C, or D Date of Diagnosis	Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D Date of Diagnosis is the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests.
Paraplegia	Paraplegia means complete and irreversible loss of all motion and all practical use of both legs, as determined by a Medical Professional.
Pathologist	Pathologist means a Medical Professional who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.
Permanent Paralysis	Permanent Paralysis means a definite Diagnosis of Quadriplegia, Paraplegia, Diplegia or Hemiplegia. The Diagnosis of Paralysis must be made by a Medical Professional . The spinal cord Injury causing the Paralysis must occur on or after the Covered Person's effective date of coverage and while this Rider is in force for benefits to be payable.
Permanent Paralysis Due to a Covered Accident Date of Diagnosis	Permanent Paralysis Due to a Covered Accident Date of Diagnosis The date a Medical Professional diagnoses the paralysis or severed spinal cord.
Quadriplegia	Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs, as determined by a Medical Professional.
Ruptured Brain Aneurysm	Ruptured Brain Aneurysm means an abnormal bulge or ballooning of a blood vessel in the brain that has ruptured causing bleeding into the brain, as confirmed by CT, CT angiography (CTA), cerebrospinal fluid test, MRI, or MRI and angiography MRA.
Ruptured Brain Aneurysm Date of Diagnosis	Ruptured Brain Aneurysm Date of Diagnosis is the date a test or series of tests, including but not limited to computerized tomography (CT); cerebrospinal fluid test; magnetic resonance imaging (MRI); or cerebral angiogram, confirms the ruptured aneurysm.
Severe Burns	Severe Burns means a Diagnosis, by a Medical Professional board-certified as a Plastic Surgeon, that the Covered Person has sustained third degree burns resulting from a Covered Accident covering at least 20% of the total body surface area (TBSA) of the Covered Person's body.
Severe Burns Date of Diagnosis	Severe Burn Date of Diagnosis is the date, following the Covered Person's effective date of coverage under this Rider, that the Covered Person was involved in a Covered Accident resulting in a positive Diagnosis by a Medical Professional of a Severe Burn.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Critical Illness Rider of the Group Benefits Fixed Indemnity 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.

DEFINITIONS

The definitions below are for all **Critical Illness Rider** of the Group Benefits Fixed Indemnity 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. 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.

DEFINITION TERM[1]	DEFINITION MEANING[1]
CRITICAL ILLNESS RIDER	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Skin Cancer	Skin Cancer means cancer on the surface of the body (skin) that may be: • melanomas that are in situ, stage 0, or stage 1; • basal cell carcinoma; or • squamous cell carcinoma of the skin.
Skin Cancer Date of Diagnosis	Skin Cancer Date of Diagnosis means the date the tissue specimen is taken on which the Diagnosis of Skin Cancer is based.
Stroke	Stroke means the sudden death of brain cells due to lack of oxygen, caused by blockage of blood flow or rupture of an artery to the brain. The following are not to be construed as a Stroke for purposes of this Rider: • transient ischemic attack; • brain injury related to trauma or infection; • brain injury associated with hypoxia/anoxia or hypotension; • vascular disease affecting the eye or optic nerve; and • ischemic disorders of the vestibular system. If a Stroke results in death, an autopsy confirmation verifying Stroke as the cause of death will be accepted.
Stroke Date of Diagnosis	Stroke Date of Diagnosis is the date a Stroke occurs, and the Diagnosis must be supported by: • evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the stroke, including but not limited to: impaired motor function, altered sensation, vision loss, difficulty swallowing, or cognitive impairment; and • confirmatory neuroimaging studies consistent with the diagnosis of a new stroke.
Sudden Cardiac Arrest	Sudden Cardiac Arrest means the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension. Sudden Cardiac Arrest does not mean a Heart Attack (Myocardial Infarction).
Sudden Cardiac Arrest Date of Diagnosis	Sudden Cardiac Arrest Date of Diagnosis is the date the pumping action of the heart fails based on the Sudden Cardiac Arrest definition.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Critical Illness Rider of the Group Benefits Fixed Indemnity 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.

DEFINITIONS

The definitions below are for all **Critical Illness Rider** of the Group Benefits Fixed Indemnity 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. 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.

DEFINITION TERM[1]	DEFINITION MEANING[1]
CRITICAL ILLNESS RIDER	Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.
Transient Ischemic Attack (TIA)	Transient Ischemic Attack (TIA) means a brief episode of neurologic dysfunction, caused by local brain or retinal ischemia, with clinical symptoms typically lasting less than one hour, during which dizziness, blurred vision, numbness on one side of the body and other symptoms of a stroke may occur. Diagnosis of the TIA must meet all the following requirements: • The Covered Person must have sought medical intervention for a TIA within 24 hours of the onset of the TIA; • There is a new ischemic event with no cerebral infarction or tissue damage and reversible impairment as confirmed by Clinical Diagnosis; • Clinical Diagnosis includes documentation of recommended treatment for Stroke prevention; and, • The impairment must be focal and confined to an area of the brain perfused by a specific artery.
Paraplegia	Transient Ischemic Attack (TIA) Date of Diagnosis is the date of transient ischemic change is confirmed by a Medical Professional 's physical and neurological exam and other possible causes of the Covered Person's symptoms are ruled out by testing, including but not limited to: Angiography; Arteriography; Carotid ultrasonography or ultrasound; Computerized tomography (CT) or computerized tomography angiography (CTA); Echocardiography; or Magnetic resonance imaging (MRI).

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for Critical Illness Rider of the Group Benefits Fixed Indemnity 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.

DISCLAIMERS FOR GROUP BENEFITS FIXED INDEMNITY INSURANCE

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

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 Rider and is subject to the terms, conditions, limitations, and exclusions of the Group Policy and Certificate(s) of Insurance and Rider. Coverage may vary or may not be available in all states. You'll find complete coverage details in the Certificate(s) of Insurance and Rider. Group Benefits Fixed Indemnity 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 Disclaimer

The optional supplemental UBA membership 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 membership plans are not intended to supplement, not replace, comprehensive health insurance coverage. UBA membership 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 membership 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 Benefits Fixed Indemnity Insurance Disclaimer

You hereby request Group Benefits Fixed Indemnity Insurance that includes the Critical Illness Rider, 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 ID. 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 and Rider 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 and Rider 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. Note, there are links on the Sm&rt Med brochure that are clickable for each state Certificate of Insurance and Riders. You can send the brochure along and instruct the member to open the certificate of insurance from the link in the brochure.)

DISCLAIMERS FOR GROUP BENEFITS FIXED INDEMNITY INSURANCE

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

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 membership plans 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 membership plans 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 membership plans have been purchased along with UBA membership, you will be charged only one monthly payment for the total cost of all purchased membership plans. 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 ID. Cards in the mail within 14 days of purchase. Digital copies of your ID. Cards, as well as all Membership Guides and Certificates of Insurance and Riders 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 membership plans 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.

Importance of Reviewing Your State-Specific Certificate of Insurance

When considering supplemental gap insurance plans, it is crucial for members to thoroughly review their state-specific Certificate of Insurance. Doing so ensures a comprehensive understanding of the schedule of benefits, definitions, terms, limitations, and exclusions that apply specifically to their state. **Coverage details can vary significantly from one state to another in some cases, certain coverages may not be available at all.** By familiarizing yourself with this document, members can gain clarity on how their group insurance will function, ensuring they are well-informed about the scope and limitations of their coverage. This proactive approach is vital for making informed decisions and maximizing the benefits of their group insurance plan.

SM&RT MED - PREMIUM MEMBERSHIP PLAN - CERTIFICATES & GUIDES	
STATE	**LINK TO DOWNLOAD CERTIFICATE OF INSURANCE, UBA GUIDE, & BB 4.0 GUIDE**
ARIZONA	https://www.ubamembers.com/certs_sm&rtmedpremium_AZ.pdf
GEORGIA	https://www.ubamembers.com/certs_sm&rtmedpremium_GA.pdf
KENTUCKY	https://www.ubamembers.com/certs_sm&rtmedpremium_KY.pdf
MISSISSIPPI	https://www.ubamembers.com/certs_sm&rtmedpremium_MS.pdf
NEBRASKA	https://www.ubamembers.com/certs_sm&rtmedpremium_NE.pdf
NORTH CAROLINA	https://www.ubamembers.com/certs_sm&rtmedpremium_NC.pdf
OKLAHOMA	https://www.ubamembers.com/certs_sm&rtmedpremium_OK.pdf
TENNESSEE	https://www.ubamembers.com/certs_sm&rtmedpremium_TN.pdf
TEXAS	https://www.ubamembers.com/certs_sm&rtmedpremium_TX.pdf
UBA Membership Guide	https://www.ubamembers.com/sample_ubamembership.pdf
Benefit Boost 4.0 Guide	https://www.ubamembers.com/sample_bb4_UBA.pdf

SM&RT MED - PREMIUM MEMBERSHIP PLAN - MONTHLY PLAN COSTS			
FAMILY MAKE-UP	**MONTHLY PLAN COST**	**UBA MONTHLY DUES**	**TOTAL MONTHLY COST**
INDIVIDUAL	$385.91	$10	$395.91
INDIVIDUAL & SPOUSE	$766.47	$10	$776.47
INDIVIDUAL & CHILD(REN)	$744.83	$10	$754.83
FAMILY	$1,100.73	$10	$1,110,73

*The following monthly insurance rates apply to coverage underwritten by United States Fire Insurance Company[1]. Your overall total association membership dues for the optional supplemental Sm&rt Med Premium membership plan also include these monthly insurance rates: [1]Group Benefits Fixed Indemnity Insurance: $295.91 (Member), $616.47 (Member+Spouse), $554.83 (Ind+Children), $850.73 (Family). The Sm&rt Med Premium membership plan also includes costs for Benefit Boost 4.0, agent compensation and administration.

Importance of Reviewing Your State-Specific Certificate of Insurance

When considering Group Benefits Fixed Indemnity Insurance, it is crucial for members to thoroughly review their state-specific Certificate of Insurance. Doing so ensures a comprehensive understanding of the schedule of benefits, definitions, terms, limitations, and exclusions that apply specifically to their state. **Coverage details can vary significantly from one state to another in some cases, certain coverages may not be available at all.** By familiarizing yourself with this document, members can gain clarity on how their group insurance will function, ensuring they are well-informed about the scope and limitations of their coverage. This proactive approach is vital for making informed decisions and maximizing the benefits of their group insurance plan.

SM&RT MED - PLUS MEMBERSHIP PLAN - CERTIFICATES & GUIDES	
STATE	**LINK TO DOWNLOAD CERTIFICATE OF INSURANCE, UBA GUIDE, & BB 4.0 GUIDE**
ARIZONA	https://www.ubamembers.com/certs_sm&rtmedplus_AZ.pdf
GEORGIA	https://www.ubamembers.com/certs_sm&rtmedplus_GA.pdf
KENTUCKY	https://www.ubamembers.com/certs_sm&rtmedplus_KY.pdf
MISSISSIPPI	https://www.ubamembers.com/certs_sm&rtmedplus_MS.pdf
NEBRASKA	https://www.ubamembers.com/certs_sm&rtmedplus_NE.pdf
NORTH CAROLINA	https://www.ubamembers.com/certs_sm&rtmedplus_NC.pdf
OKLAHOMA	https://www.ubamembers.com/certs_sm&rtmedplus_OK.pdf
TENNESSEE	https://www.ubamembers.com/certs_sm&rtmedplus_TN.pdf
TEXAS	https://www.ubamembers.com/certs_sm&rtmedplus_TX.pdf
UBA Membership Guide	https://www.ubamembers.com/sample_ubamembership.pdf
Benefit Boost 4.0 Guide	https://www.ubamembers.com/sample_bb4_UBA.pdf

SM&RT MED - PLUS MEMBERSHIP PLAN - MONTHLY PLAN COSTS			
FAMILY MAKE-UP	**MONTHLY PLAN COST**	**UBA MONTHLY DUES**	**TOTAL MONTHLY COST**
INDIVIDUAL	$301.16	$10	$311.16
INDIVIDUAL & SPOUSE	$589.93	$10	$599.93
INDIVIDUAL & CHILD(REN)	$585.93	$10	$595.93
FAMILY	$857.10	$10	$867.10

*The following monthly insurance rates apply to coverage underwritten by United States Fire Insurance Company[1]. Your overall total association membership dues for the optional supplemental Sm&rt Med Plus membership plan also include these monthly insurance rates: [1]Group Benefits Fixed Indemnity Insurance: $211.16 (Member), $439.93 (Member+Spouse), $395.93 (Ind+Children), $607.10 (Family). The Sm&rt Med Plus membership plan also includes costs for Benefit Boost 4.0, agent compensation and administration.

Importance of Reviewing Your State-Specific Certificate of Insurance

When considering Group Benefits Fixed Indemnity Insurance, it is crucial for members to thoroughly review their state-specific Certificate of Insurance. Doing so ensures a comprehensive understanding of the schedule of benefits, definitions, terms, limitations, and exclusions that apply specifically to their state. **Coverage details can vary significantly from one state to another in some cases, certain coverages may not be available at all.** By familiarizing yourself with this document, members can gain clarity on how their group insurance will function, ensuring they are well-informed about the scope and limitations of their coverage. This proactive approach is vital for making informed decisions and maximizing the benefits of their group insurance plan.

SM&RT MED - VALUE MEMBERSHIP PLAN - CERTIFICATES & GUIDES	
STATE	**LINK TO DOWNLOAD CERTIFICATE OF INSURANCE, UBA GUIDE, & BB 4.0 GUIDE**
ARIZONA	https://www.ubamembers.com/certs_sm&rtmedvalue_AZ.pdf
GEORGIA	https://www.ubamembers.com/certs_sm&rtmedvalue_GA.pdf
KENTUCKY	https://www.ubamembers.com/certs_sm&rtmedvalue_KY.pdf
MISSISSIPPI	https://www.ubamembers.com/certs_sm&rtmedvalue_MS.pdf
NEBRASKA	https://www.ubamembers.com/certs_sm&rtmedvalue_NE.pdf
NORTH CAROLINA	https://www.ubamembers.com/certs_sm&rtmedvalue_NC.pdf
OKLAHOMA	https://www.ubamembers.com/certs_sm&rtmedvalue_OK.pdf
TENNESSEE	https://www.ubamembers.com/certs_sm&rtmedvalue_TN.pdf
TEXAS	https://www.ubamembers.com/certs_sm&rtmedvalue_TX.pdf
UBA Membership Guide	https://www.ubamembers.com/sample_ubamembership.pdf
Benefit Boost 4.0 Guide	https://www.ubamembers.com/sample_bb4_UBA.pdf

SM&RT MED - VALUE MEMBERSHIP PLAN - MONTHLY PLAN COSTS			
FAMILY MAKE-UP	**MONTHLY PLAN COST**	**UBA MONTHLY DUES**	**TOTAL MONTHLY COST**
INDIVIDUAL	$247.25	$10	$257.25
INDIVIDUAL & SPOUSE	$477.61	$10	$487.61
INDIVIDUAL & CHILD(REN)	$484.85	$10	$494.85
FAMILY	$702.10	$10	$712.10

*The following monthly insurance rates apply to coverage underwritten by United States Fire Insurance Company[1]. Your overall total association membership dues for the optional supplemental Sm&rt Med Value membership plan also include these monthly insurance rates: [1]Group Benefits Fixed Indemnity Insurance: $157.25 (Member), $327.61 (Member+Spouse), $294.85 (Ind+Children), $452.10 (Family). The Sm&rt Med Value membership plan also includes costs for Benefit Boost 4.0, agent compensation and administration.

Importance of Reviewing Your State-Specific Certificate of Insurance

When considering Group Benefits Fixed Indemnity Insurance, it is crucial for members to thoroughly review their state-specific Certificate of Insurance. Doing so ensures a comprehensive understanding of the schedule of benefits, definitions, terms, limitations, and exclusions that apply specifically to their state. **Coverage details can vary significantly from one state to another in some cases, certain coverages may not be available at all.** By familiarizing yourself with this document, members can gain clarity on how their group insurance will function, ensuring they are well-informed about the scope and limitations of their coverage. This proactive approach is vital for making informed decisions and maximizing the benefits of their group insurance plan.

SM&RT MED - BASIC MEMBERSHIP PLAN - CERTIFICATES & GUIDES	
STATE	**LINK TO DOWNLOAD CERTIFICATE OF INSURANCE, UBA GUIDE, & BB 4.0 GUIDE**
ARIZONA	https://www.ubamembers.com/certs_sm&rtmedbasic_AZ.pdf
GEORGIA	https://www.ubamembers.com/certs_sm&rtmedbasic_GA.pdf
KENTUCKY	https://www.ubamembers.com/certs_sm&rtmedbasic_KY.pdf
MISSOURI	https://www.ubamembers.com/certs_sm&rtmedbasic_MO.pdf
NEBRASKA	https://www.ubamembers.com/certs_sm&rtmedbasic_NE.pdf
NORTH CAROLINA	https://www.ubamembers.com/certs_sm&rtmedbasic_NC.pdf
OKLAHOMA	https://www.ubamembers.com/certs_sm&rtmedbasic_OK.pdf
TENNESSEE	https://www.ubamembers.com/certs_sm&rtmedbasic_TN.pdf
TEXAS	https://www.ubamembers.com/certs_sm&rtmedbasic_TX.pdf
UBA Membership Guide	https://www.ubamembers.com/sample_ubamembership.pdf
Benefit Boost 4.0 Guide	https://www.ubamembers.com/sample_bb4_UBA.pdf

SM&RT MED - BASIC MEMBERSHIP PLAN - MONTHLY PLAN COSTS			
FAMILY MAKE-UP	**MONTHLY PLAN COST**	**UBA MONTHLY DUES**	**TOTAL MONTHLY COST**
INDIVIDUAL	$196.10	$10	$206.10
INDIVIDUAL & SPOUSE	$371.04	$10	$381.04
INDIVIDUAL & CHILD(REN)	$388.94	$10	$398.94
FAMILY	$555.04	$10	$565.04

*The following monthly insurance rates apply to coverage underwritten by United States Fire Insurance Company[1]. Your overall total association membership dues for the optional supplemental Sm&rt Med Basic membership plan also include these monthly insurance rates: [1]Group Benefits Fixed Indemnity Insurance: $106.10 (Member), $221.04 (Member+Spouse), $198.94 (Ind+Children), $305.04 (Family). The Sm&rt Med Basic membership plan also includes costs for Benefit Boost 4.0, agent compensation and administration.

Sm&rt Med Plans Sales Script

Introduction

Hello, and thank you for your interest in Sm&rt Med Plans! My name is [Your Name], and I'm excited to share how our plans can transform your approach to healthcare expenses. Let's explore why Sm&rt Med Plans are the smart choice for supplemental coverage. It's important to note that Sm&rt Med Plans are intended to complement your primary health insurance, not replace it.

Discovering Sm&rt Med Plans

We understand that managing medical costs can be overwhelming. That's why we've designed our plans to offer broad indemnity coverage while helping to significantly reduce out-of-pocket medical expenses. Our membership plans cover a wide range of medical needs, ensuring you have access to essential services without the stress of unexpected bills.

Key Benefits

1. First Dollar Insurance Benefits
   - Our membership plans include Group Benefits Fixed Indemnity Insurance, underwritten by the United States Fire Insurance Company. This insurance covers a range of medical expenses, including hospitalization, emergency care, surgeries, diagnostics, and wellness services.
   - Additionally, our plans offer a Critical Illness Rider, underwritten by the United States First Insurance Company. This rider provides support during difficult times when confronted with severe conditions such as cancer, heart attacks, strokes, and more.
2. Direct Primary Care

With your Sm&rt Med membership, you gain unlimited and seamless access to in-office doctor visits, urgent care visits, and virtual consultations via Healthcare2U. You can easily schedule appointments using just one phone number, and since Direct Primary Care is not insurance, no claim forms are necessary.

Why Choose Sm&rt Med Plans?

- Accessible and Economical
  - Our plans are designed to put help you put your medical needs first. This empowers you to prioritize well-being without compromise.
- Simple Claims Process
  - While claims need to be filed to access benefits, our process is straightforward and minimizes hassle. Transparent coverage limits ensure you focus on medical needs, not paperwork.
- Tailored for Your Needs
  - Whether you're an individual, family, or entrepreneur, Sm&rt Med Plans offer personalized support to meet your unique medical needs.

Detailing the Sm&rt Med Plan for Prospective Customers

In this part of our discussion, you will delve into the key aspects of the Sm&rt Med Plan that you're considering for your potential clients. This includes explaining comprehensive information on the plan's features, disclaimers, schedule of benefits, as well as any limitations and exclusions specific to their state.

To ensure that you have access to all the necessary information, please refer to the brochure and the state-specific Certificates of Insurance. The brochure conveniently includes clickable links to these certificates for easy viewing. It's crucial to review and confirm the client's understanding of the limitations and exclusions applicable to the state certificate where you are selling the plan.

Before purchasing the Sm&rt Med Plan, it's important to emphasize to customers that they must have primary health coverage, as this plan is designed to complement their existing insurance.

• Disclaimers, Limitations, and Exclusions: Ensure that you cover all disclaimers, limitations, and exclusions comprehensively.

• Schedule of Benefits: Carefully review and confirm the potential client's understanding of the Schedule of Benefits for both the Sm&rt Med plan and the CI Rider you are presenting to the client. Read each item and confirm the potential client's understanding of the following:

- o Available Indemnity Amounts
- o Lifetime Maximums
- o The maximum number of days available in a Certificate Period
- o Any restrictions on benefits
- o Benefit Maximums
- o Waiting Periods
- o State Variations (if applicable)

It is essential to clearly convey that this membership plan functions as a fixed indemnity insurance plan with a critical illness rider, in addition to offering non-insurance direct primary care services. Moreover, it does not fulfill the requirements for comprehensive major medical insurance as outlined by the ACA.

Closing - Begin Your Sm&rt Med Membership Today!

Thank you for considering the UBA Sm&rt Med membership plan to support your medical needs. This plan is exclusively available to members of the United Business Association (UBA). While joining the UBA does not require you to sign up for supplemental insurance, becoming a member is essential to enroll in the Sm&rt Med plan. We are committed to assisting you in reducing a portion of your out-of-pocket medical expenses.

Are you read to discover the benefits covered under Sm&rt Med Plans? Enrolling is simple and straightforward. Let's get started...

Enrollment Application Process

• The agent initiates the enrollment application by collecting family information such as names, addresses, dates of birth, and details about any dependents, including a spouse or child. Following this, they will address the qualifying underwriting health questions.

• If the member does not qualify based on the knockout questions:
- Inform them that they do not qualify.
- Provide alternative options with different types of insurance plans.

• If the member qualifies based on the underwriting questions:
- Continue with the enrollment application.
- Notify them that they will receive an email containing a link to finalize the enrollment process. This includes:
  - o Reviewing the application
  - o Agreeing to the disclaimers and notices
  - o E-signing the enrollment application

•Once this is completed, the member will receive another email with a link to the Member Portal, where they can:
- Download certificates of insurance
- Access brochures
- Obtain digital ID cards
- Find claim forms
- View copies of their enrollment forms

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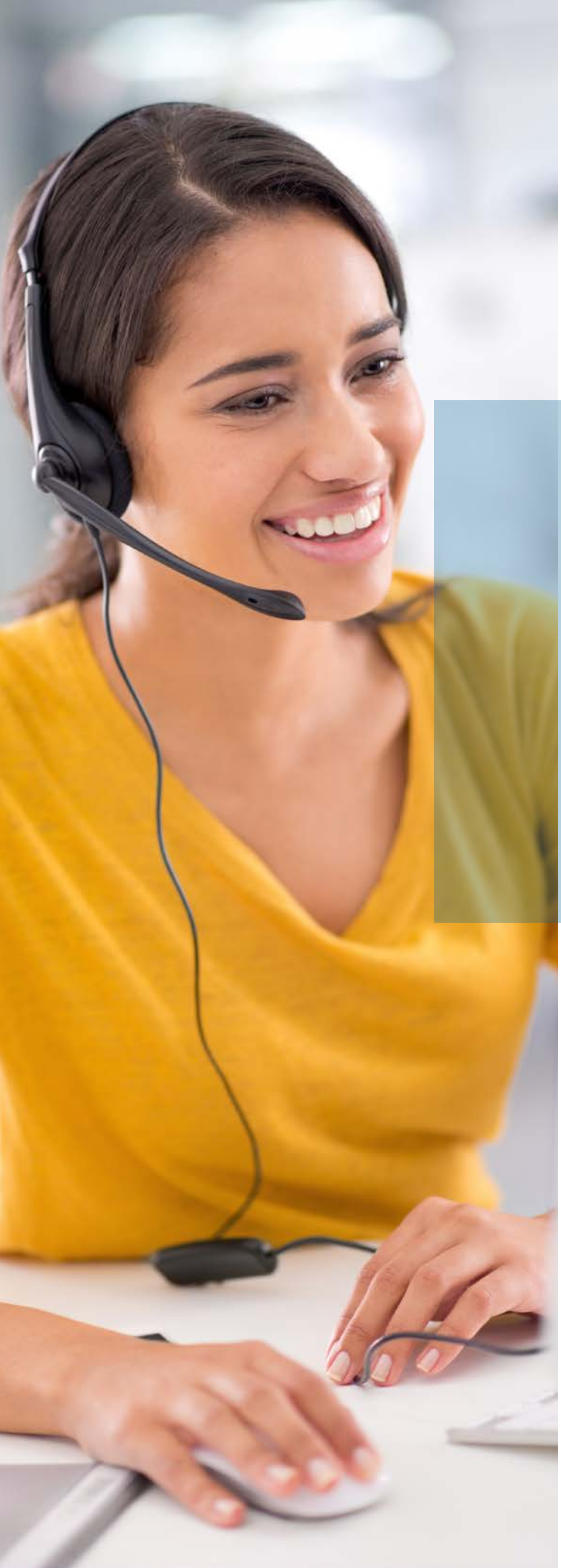

SM&RT MED

AVAILABLE TO UBA MEMBERS

Members age 18-65*

Eligible Spouse up to age 65*

Eligible Dependents up to age 26 (up to age 25 in TX)*

**Coverage ends for primary member and covered spouse when they turn 65 and ends for covered dependents when they turn age 26 (age 25 in TX).*

HOW TO **CONTACT US**

Agent Customer Service: **800-964-8331**

Member Customer Service: **866-438-4274**

Agent Customer ServiceEmail:
info@healthyamericainsurance.com

Member Customer Service Email:
info@ubamembers.com

Link to Sm&rtMed Brochure:

https://www.ubamembers.com/Sm&rtMedBrochure.pdf

Link to Sm&rt Med Claim Form:

https://www.ubamembers.com/UBASm&rtMedClaimForm-v1125.pdf

United Business Association
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https://www.ubamembers.com
https://members.ubaapplication.com