Super Gap Plan™
Member Driven Value.
Group Insurance Certificates

These Group Insurance Certificates are for the Super Gap Plan™ purchased on or after 04.05.18 or for all Super Gap Plans on or after 06.01.18. You can call your personal member concierge at 866.438.4274 for any questions with your certificates.
GROUP BENEFITS – HOSPITAL FIXED INDEMNITY
CERTIFICATE OF INSURANCE

POLICYHOLDER: United Business Association
POLICY NUMBER: US1068698
POLICY EFFECTIVE DATE: March 15, 2018
CERTIFICATEHOLDER: Please see the Enrollment Form
CERTIFICATE EFFECTIVE DATE: Please see the certification section of the Enrollment Form
CERTIFICATE EXPIRATION DATE: Until Cancelled

This Certificate is evidence of the Covered Person’s insurance under the Policy that We have issued to the Policyholder named above. The provisions of the Policy are summarized in this Certificate. This Certificate replaces any other Certificate We may have previously provided under the Policy.

The Policy is issued in the state of Texas.
The Policy is governed by the laws of the state where it was delivered.

The Policy is a legal contract between the Policyholder and United States Fire Insurance Company (herein referenced as “the Company”). The Policy alone is the only contract under which payment will be made. The Policy may be inspected at the office of the Policyholder.

THIS IS A CERTIFICATE OF INSURANCE FOR A LIMITED FIXED INDEMNITY POLICY.
IT PAYS BENEFITS REGARDLESS OF ANY OTHER INSURANCE.
THE POLICY IS NOT A MAJOR MEDICAL OR
COMPREHENSIVE MEDICAL HEALTHCARE POLICY.
PLEASE READ THIS CERTIFICATE CAREFULLY.

THE POLICY IS OPTIONALLY RENEWABLE.
Non-Participating Insurance

Signed for United States Fire Insurance Company By:

Marc J. Adee
Chairman and CEO

James Kraus
Secretary
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SCHEDULE OF BENEFITS

POLICYHOLDER: United Business Association
POLICY EFFECTIVE DATE: March 15, 2018
POLICY NUMBER: US1068698
PREMIUM DUE DATE: Per Option Chosen on the Enrollment form
CERTIFICATEHOLDER: Please see the Enrollment Form
CERTIFICATE EFFECTIVE DATE: Please see the certification section of the Enrollment Form
CERTIFICATE EXPIRATION DATE: Until Cancelled

CLASSES OF ELIGIBLE PERSONS:

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

Class 1: All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP AME, GAP MAX, Super GAP, & the GAP ER plan options and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

SCHEDULE OF BENEFITS

LIMITED FIXED INDEMNITY BENEFITS

COVERED BENEFIT FOR EACH COVERED PERSON:

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<td>$500 per day for days 1 - 3 for a Hospital Confinement occurring in a Policy Period</td>
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DEFINITIONS

Please note certain words used in this document have specific meanings. The male pronoun includes the female whenever used. Additional terms may be defined within the provision to which they apply.

The capitalized terms used herein are defined as follows:

"Accident" means a sudden, unforeseeable external event which:
(1) Causes Injury to one or more Covered Persons; and
(2) Occurs while coverage is in effect for the Covered Person.

“Certificate Holder” means a person to whom an insurance certificate has been issued evidencing coverage under the Policy.

“Child” 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). A Child must reside with the Insured Person in a parent-Child relationship and be eligible to be claimed as an exemption on the Insured Person’s federal income tax return. NOTE: In the event the Insured Person shares physical custody of the Child with another parent, the requirement that the Child reside with the Insured Person will be waived.

“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.

“Company” means United States Fire Insurance Company. Also hereinafter referred to as We, Us and Our.

“Complications of Pregnancy” means a condition which:
- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include:
- False labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning sickness;
- Preeclampsia; and
- Similar conditions associated with the management of a difficult pregnancy, but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is non-elective.
A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

“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” means an accidental death, dismemberment or other Injury or Sickness covered under the Policy and indicated on the Schedule of Benefits.

"Covered Person" means an Insured Person and Dependent eligible for coverage as identified in the Enrollment/Application who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, for whom proper premium payment has been made when due, and who is therefore insured under the Policy.

“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-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

“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.

“Enrollment Period” means the period agreed upon by the Policyholder and Us when an Eligible Person may enroll for coverage or an Insured may change benefit elections under the Policy.

"He", "His" and "Him" includes "she", "her" and "hers."

“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 in-patient 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 Physicians 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;
6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
7) Is not a place for drug addicts, alcoholics or the aged.
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 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 per diem charge is made by the Hospital.

“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.

"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.

“Insured Person” means an member of the Policyholder who is eligible, 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.

“Life Status Change” means an event recognized by the Policyholder and Us that qualifies the Insured Person to make changes in coverage at any time other than an Enrollment Period. The following events are all considered Life Status Changes:
1) marriage;
2) divorce, annulment or legal separation from a Spouse, Domestic Partner or Civil Union Partner;
3) birth or adoption of a child;
4) change in a Dependent child’s eligibility;
5) death of a Spouse, Domestic Partner or Civil Union Partner;
6) a change in the benefit plan or employment status of the Insured Person’s Spouse, Domestic Partner or Civil Union Partner that affects either person’s eligibility for benefits.

“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.

"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 Physician or furnished by a Hospital;
3) Performed in the least costly setting required by the condition;
4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:
- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Covered Person, the Covered Person's family, Physician, 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 less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

“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" means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

“Optionally Renewable” means renewal is at the option of United States Fire Insurance Company.

“Physician” means a person who is a qualified practitioner of medicine. As such, He or She must be acting within the scope of his/her license under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person’s Spouse, Domestic Partner or Civil Union Partner, son, daughter, father, mother, brother or sister or other relative.”

“Policy Period” means, initially, the period of time from the Effective Date of the Policy until the first Policy Anniversary Date, and thereafter each subsequent 12 consecutive months provided coverage remains in force.

“Policyholder” means the entity shown as the Policyholder in the Schedule of Benefits.
“Pre-existing Condition” means a disease or physical condition for which medical advice or treatment was recommended or received by the Covered Person during the 12 months prior to the Covered Person’s Effective Date of coverage.

“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” means a facility that provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, 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 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.

“Spouse” means lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Partner.

“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.

“We, Our, Us” means United States Fire Insurance Company underwriting this insurance or its authorized agent.

“You, Your, Yours, He or She” means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.
ELIGIBILITY FOR INSURANCE

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

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

An Insured Person’s Dependent(s), as applicable, 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; or

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

EFFECTIVE DATE OF INSURANCE

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:
An Eligible Person will become insured under the Policy, provided proper premium payment is made, on the latest of:
(1) The Effective Date of the Policy; or
(2) The day He becomes eligible, subject to any required Eligibility Waiting Period, according to the reference shown in the Application/Enrollment Form

Newborn Children Coverage: We will provide coverage for a newborn Child from the moment of birth. The Insured Person must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate at the expiration of the initial 31 day period.

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.

Newborn Child Exception: This section does not apply to a newborn Child at that Child’s birth 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.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in the Insured Person’s home. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate at the expiration of the initial 31 day period.

Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child, will be covered on the same basis as an adopted Child.
TERMINATION DATE OF INSURANCE:

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 on the last day of the period for which premiums have been earned.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate 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.

Insured Person’s Termination Date
Insurance for an Insured Person will end on the earliest of:
(1) The date He is no longer in an Eligible Class.
(2) The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
   (a) The date the premium is fully earned; or
   (b) The Expiration Date of the Policy.
   This does not include Reserve or National Guard duty for training;
(3) The end of the period for which the last premium contribution is made; or
(4) The date the Policy is terminated; or
(5) The date the Insured Person requests, in writing, that his/her coverage be terminated; or

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 last day of the period for which premiums have been paid.

PREMIUM PROVISIONS

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 period for which premium was paid.

The Company has the right to rely upon the accuracy of the Policyholder’s calculations and to require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.

**Grace Period:**
A Grace Period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Policyholder pays all the premiums due by the last day of the Grace Period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Policy. Coverage will end if the premium is not paid by the end of the Grace Period.

**Changes in Premium Rate**
The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Policyholder's most recent address in Our records.

No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur:
1) A change in the terms of the Policy.
2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
3) A change in any federal or state law or regulation affecting the Policy and 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.

**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.

The following conditions must be met for insurance to be reinstated:
1. the Policy remains in force;
2. the Insured Person and His or Her 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 Policy Period in which the Insured Person’s and His or Her Dependents’ insurance is reinstated will be applied towards the Benefit Amounts for that Policy Period.

Reinstated insurance will be effective on the later of the date the Insured Person returns to Active Service or 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.
DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under the Policy.

**Daily Hospital Confinement Benefit**

We will pay the Daily 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 Sickness; and
2. Confinement is at the direction and under the care of a Physician; and
3. While the 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.

**Daily Emergency Room Visits Benefit for Accident & Sickness**

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 Accident or Sickness.

“Emergency Room” means a trauma center, or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician’s office.

**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:

1. Suicide, attempted suicide or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
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;
4. Active participation in a riot or insurrection;
5. Treatment which arises out of, or in the course of 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’s use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person’s Physician.
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.
10. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family Member of the Covered Person.
11. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
12. Travel or activity outside the United States, except for a Medical Emergency.
13. Participation in any motorized race or speed contest.
14. Aggravation or re-injury of a prior Injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person’s Physician.
15. 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.
16. Pregnancy, except Complications of Pregnancy or childbirth unless conception occurred while coverage was in force under the Policy.
17. Elective Abortion, including complications. “Elective Abortion” means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
18. Experimental or Investigational drugs, services, supplies or procedure that is Experimental or Investigational at the time the procedure is done. For the purposes of this exclusion, “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.
19. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
20. Treatment or services provided by a private duty nurse, unless provided for in the Policy.
21. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
22. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in the Policy.
23. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in the Policy.
24. Treatment for blood or blood plasma;
25. Routine vision care.
26. 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;
27. 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;
28. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
   i. While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
   ii. While being used for any test or experimental purpose; or
   iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
iv. while traveling in any such aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of His household.

v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or

vi. An ultra light, hang-gliding, parachuting or bungee-cord jumping; Except as a fare paying passenger on a regularly scheduled commercial airline.

29. Rest cures or custodial care;
30. Prescription Drugs unless specifically provided for under the Policy.
31. Elective or cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
32. Physiotherapy services.

Pre-existing Conditions Limitation

Pre-existing Conditions will not be covered for a period of the first 12 months after the Covered Person’s Effective Date of coverage (applies to Hospital and Surgery benefits only).
CLAIM PROVISIONS

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 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.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not provided within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

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.

TIME OF PAYMENT OF CLAIMS:

Benefits due under the Policy for a Covered Loss, other than a loss for which the Policy provides installments, will be paid immediately upon receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for a Covered Loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss.

PAYMENT OF CLAIMS:

All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.
All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation 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.

**DESIGNATION OR CHANGE OF BENEFICIARY:**

Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:
1) Beneficiaries designated in writing by the Covered Person for the Policy on file with the Policyholder, if any, otherwise;
2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
3) In equal shares to the members of the first surviving class of those that follow, if any:
   a) a Covered Person’s lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner;
   b) a Covered Person’s natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
   c) a Covered Person’s parents, whether natural, step or adoptive; or
   d) a Covered person’s Sisters or Brothers, otherwise.
4) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent’s beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent’s death, the beneficiary is the Covered Person’s estate.

**CONDITIONAL CLAIM PAYMENT:**

If a Covered Person is due benefits under the Policy for a Covered Loss, and in Our opinion a third party may be liable, We will pay benefits if:
1) The Covered Person first agrees in writing to refund the lesser of:
   a) The amount of benefits We actually paid for such Covered Loss; or
   b) The amount actually received from the third party for such Covered Loss; and
2) The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, prior to Our payment of benefits under the Policy, if the third party's liability is satisfied in an amount less than the benefits payable under the Policy, We will pay the difference.
PHYSICAL EXAMINATION AND AUTOPSY:

We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy. Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.

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.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Covered Person any benefits We have paid to him for a Covered Loss which is covered under:
   (a) Workers' Compensation or similar statutory remedies available under law; or
   (b) Any employer's liability insurance.

It will be assumed that the Covered Person is in receipt of such Recovery benefits unless He gives Us proof such benefits have been denied to him.

“Recovery” means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for all losses caused by the Injury or Sickness.

SUBROGATION:

If We have paid benefits to a Covered Person for Injuries received in a Covered Accident, and in Our opinion a third party may be liable, We will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer His rights to Us. We will exercise such rights on His behalf. He further agrees to furnish Us with all relevant information and documents.

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.
GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Policy, the Application of the Policyholder (a copy of which is attached to the Policy), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, We may also make it a part of this contract.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause Us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of His death or incapacity, His beneficiary or representative. After 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.

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.

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:

We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. If either party terminates, written notice must be given to the other party at least 31 days prior to such premium due date.

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.

OTHER COVERAGE WITH US:

At any one time each Covered Person may have only one Certificate issued by Us having coverage similar to that described in the Policy. If we find a Covered Person has more than one such Certificate, coverage will be provided under the plan that has been in force for the longer period of time and any other coverage will be terminated effective immediately. If concurrent coverage is identified, We will refund premiums paid for all other Certificates for concurrent periods of coverage and provide 30 days written notice of termination to the Insured for the most recently acquired coverage.

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:**

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.

**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:**

The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

**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.
OHIO ENDORSEMENT

This Endorsement is attached to and made a part of Policy issued to United Business Association (the Policyholder).

This Endorsement is attached to and made a part of the Policy/Certificate. The provisions of this Endorsement are effective on the Effective Date and will expire concurrently with the Policy/Certificate, unless otherwise terminated.

Effective immediately the Policy/Certificate is hereby amended and modified, as follows: The following notices are added to the face page:

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE “GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE” AVAILABLE FROM THE COMPANY.

10-DAY RIGHT TO RESCIND: The Policyholder has the right to rescind the Policy until midnight of the tenth day after the date on which the Policyholder receives the Policy, by returning the Policy to Us or Our agent. No reason need be stated for the return or the rescission. Such coverage is void from the beginning when returned. Any premium paid by the Policyholder shall be promptly refunded to the Policyholder.

DEFINITIONS

If Dependent coverage is included, the Definition of “Child” is replaced with the following:

“Child” means the Insured Person’s natural Child, adopted Child (beginning with the date of Placement for Adoption) under the same terms and conditions as apply to the natural, dependent children of the Insured Person irrespective of whether the adoption has become final, foster Child, stepchild, Child subject to court or administrative ordered coverage without regard to enrollment period restrictions or other Child for whom the Insured Person has legal guardianship (proof will be required).

If a Child has this coverage through a noncustodial parent, We shall do all of the following:

(1) Provide such information to the custodial parent of the Child as may be necessary for the Child to obtain benefits through the coverage;
(2) Permit the custodial parent to submit claims for covered benefits without the approval of the noncustodial parent;
(3) Make payment on claims submitted in accordance with (2) above directly to the custodial parent or the Department of Job and Family Services.

If an Insured Person is required by a court or administrative order to provide this coverage for a Child, We shall do both of the following:

(1) If the Child is otherwise eligible for this coverage, permit the Insured Person to enroll the Child under the family coverage without regard to any enrollment period restrictions;
(2) If the Insured Person is enrolled under this coverage but fails to make application to obtain coverage for the Child, enroll the Child under the family coverage upon application of the Child's other parent or pursuant to a child support order containing provisions in compliance with state law.

We shall not terminate the Child's coverage unless We are provided satisfactory written evidence of either of the following:

(1) The court or administrative order is no longer in effect.
(2) The Child is or will be enrolled under comparable health care coverage provided by another health insurer.

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which coverage will take effect not later than the effective date of the termination of this coverage.

If Dependent coverage is included, the following Definition is added:

“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 that legal obligation.

If a Pre-existing Conditions Limitation is included, the Definition of “Pre-existing Condition” is replaced with the following:

“Pre-existing Condition” means a disease or physical condition for which medical advice or treatment was recommended or received by the Covered Person during the 6 months prior to the Covered Person’s Effective Date of coverage.

EFFECTIVE DATE OF INSURANCE

If Dependent coverage is included, the Adopted Children Coverage provision is replaced with the following:

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of Placement for Adoption. A notice of Placement for Adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate at the expiration of the initial 31 day period.

PREMIUM PROVISIONS

The Reinstatement provision is replaced with the following:

Reinstatement

If any renewal premium be not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. If the Company 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 the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Policyholder in writing of its 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 days after such date. In all other respects the Policyholder and the Company 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 indorsed 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 days prior to the date of reinstatement.

CLAIM PROVISIONS

The second paragraph of the Notice of Claim provision is deleted and shall not apply.

The first paragraph of the Time of Payment of Claims provision is replaced with the following:

Benefits due under the Policy for a Covered Loss, other than a loss for which the Policy provides installments, will be paid immediately upon, or within 30 days after, receipt of due written proof of such loss.
GENERAL PROVISIONS

The phrase “or with respect to eligibility for coverage” is deleted from the last sentence of the second paragraph under the Entire Contract; Changes provision.

The Certificate of Insurance provision is replaced with the following:

CERTIFICATES OF INSURANCE:
A Certificate of Insurance will be delivered to the Policyholder for delivery to each Insured Person. Each Certificate will list the benefits, conditions and limits of the Policy. It will state to whom the benefits will be paid.

The Conformity With State Statutes provision is replaced with the following:

CONFORMITY WITH STATE STATUTES:
Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Insured Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

This Endorsement does not change coverage or provisions in any other way and is subject to all provisions, terms, and conditions of the Policy/Certificate.

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.

Signed for United States Fire Insurance Company By:

Marc J. Adee
Chairman and CEO

James Kraus
Secretary
Ohio Guaranty Notice

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE OHIO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Section 3956.18(B)(1) of the Ohio Insurance Code requires all Group Life and Health insurers to provide a summary of the basic provisions of the Ohio Life and Health Insurance Guaranty Association Act.

Any questions concerning this summary should be directed to the Ohio Life and Health Insurance Guaranty Association or to the Ohio Insurance Department at the address below.

NOTICE
Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. HOWEVER, INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE GUARANTY ASSOCIATION TO INDUCE YOU TO PURCHASE ANY KIND OF INSURANCE POLICY.

The Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, Ohio 43220

Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43268-0588

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law’s coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone’s rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE
Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.
EXCLUSIONS FROM COVERAGE
However, persons holding policies are not protected by this association if:
• they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
• the insurer was not authorized to do business in this state;
• their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:
• any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
• any policy of reinsurance (unless an assumption certificate was issued);
• interest rate yields that exceed an average rate;
• dividends;
• credits given in connection with the administration of a policy by a group contract holder;
• employers’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. The association will not pay more than $100,000 in cash surrender values, $500,000 in major medical insurance benefits, $300,000 in disability or long-term care insurance benefits, $100,000 in other health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the association will pay a maximum of $300,000, except for coverage involving major medical insurance benefits, for which the maximum of all coverages is $500,000.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§401, 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.
When used throughout this document “Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we’ve made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don’t have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

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

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

Grievance
(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.

(2) A statement of the reviewer’s understanding of the Grievance.

(3) The specific reason(s) for the reviewer’s decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.

(4) A reference to the evidence or documentation used as the basis for the decision.

(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.

(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

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

(1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;

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

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

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

The panel must be comprised of persons who:

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

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

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

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

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

**EXPEDITED REVIEW**

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

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

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.
PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern
When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?
We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?
If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?
We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us
You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Crum & Forster A&H Division
5 Christopher Way, 2nd Floor
Eatontown, New Jersey  07724
GROUP BENEFITS
ACCIDENT ONLY CERTIFICATE

POLICYHOLDER: United Business Association

POLICY NUMBER: US1068696

CERTIFICATEHOLDER: Please see Enrollment Form

EFFECTIVE DATE: March 15, 2018

EXPIRATION DATE: Until Cancelled

The Policy and this Certificate is governed by the laws of the state where it was delivered.

The Certificate is a legal contract between the Certificate holder and United States Fire Insurance Company (herein referenced as “the Company”).

The Company agrees to provide insurance, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in the Policy and this Certificate.

The Insurance Company, the Policyholder and the Certificate holder have agreed to all the terms and conditions of the Policy and this Certificate.

The Policy and this certificate and the coverage provided by it become effective at 12:01 A.M. at the address of the Certificate holder on the Certificate Effective Date shown above. It continues in effect in accordance with the provisions set forth in the Policy and this Certificate.

THIS IS LIMITED BENEFIT ACCIDENT ONLY COVERAGE.
READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS CERTIFICATE PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.

THE POLICY and THIS CERTIFICATE ARE NOT RENEWABLE.

Non-Participating Insurance

Signed for United States Fire Insurance Company By:

Marc J. Adee
Chairman and CEO

James Kraus
Secretary
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SCHEDULE OF BENEFITS

POLICYHOLDER: United Business Association
CERTIFICATE NUMBER: Please see Enrollment Form
CERTIFICATEHOLDER: Please see Enrollment Form
EFFECTIVE DATE: Please see Enrollment Form
PREMIUM DUE DATE: Please see Enrollment Form

CLASSES OF ELIGIBLE PERSONS:

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

Class 1: All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP AME or the GAP MAX plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

Class 2: All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP Plus plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

Class 3: All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the Super GAP plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

Class 4: All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP Plus 5000 plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.
SCHEDULE OF BENEFITS – CLASS 1

Class 1: All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP AME or the GAP MAX plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH, HEARING BENEFITS

Principal Sum: $5,000

Time Period for Loss: 365 days

ACCIDENT MEDICAL EXPENSE BENEFIT

Annual Maximum for all Accident Medical $10,000

Loss Period (first Covered Expenses must be incurred within) 90 days after the Covered Accident or Injury

Benefit Period: 1 year from the date of the Covered Accident or Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary.

Deductible: $100.00

Terms of Payment Full Excess

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

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Covered Person, per Covered Accident basis.
SCHEDULE OF BENEFITS – CLASS 2

Class 2: All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP Plus plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH, HEARING BENEFITS

Principal Sum: $5,000

Time Period for Loss: 365 days

ACCIDENT MEDICAL EXPENSE BENEFIT

- Annual Maximum for all Accident Medical: $7,350
- Loss Period (first Covered Expenses must be incurred within): 90 days after the Covered Accident or Injury
- Benefit Period: 1 year from the date of the Covered Accident or Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary.
- Deductible: $100.00

Terms of Payment: Full Excess

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

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Covered Person, per Covered Accident basis.
SCHEDULE OF BENEFITS – CLASS 3

Class 3: All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the Super GAP plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH, HEARING BENEFITS

Principal Sum: $5,000

Time Period for Loss: 365 days

ACCIDENT MEDICAL EXPENSE BENEFIT

Annual Maximum for all Accident Medical $25,000

Loss Period (first Covered Expenses must be incurred within) 90 days after the Covered Accident or Injury

Benefit Period: 1 year from the date of the Covered Accident or Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary.

Deductible: $100.00

Terms of Payment Full Excess

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

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Covered Person, per Covered Accident basis.
SCHEDULE OF BENEFITS – CLASS 4

Class 4: All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP Plus 5000 plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH, HEARING BENEFITS

Principal Sum: $2,500

Time Period for Loss: 365 days

ACCIDENT MEDICAL EXPENSE BENEFIT

Annual Maximum for all Accident Medical $5,000

Loss Period (first Covered Expenses must be incurred within) 90 days after the Covered Accident or Injury

Benefit Period: 1 year from the date of the Covered Accident or Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary.

Deductible: $100.00

Terms of Payment Full Excess

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

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

The male pronoun includes the female whenever used.

For the purposes of the Policy and this Certificate the capitalized terms used herein are defined as follows:

Additional terms may be defined within the provision to which they apply.

"Accident" means a sudden, unforeseeable external event which:
(1) Causes Injury to one or more Covered Persons; and
(2) Occurs while coverage is in effect for the Covered Person.

"Aircraft" means a vehicle which:
(1) Has a valid certificate of airworthiness; and
(2) Is being flown by a pilot with a valid license appropriate to the aircraft.

"Benefit Period" means the period of time from the date of the Accident causing the Injury for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.

Certificate Holder means a person to whom this insurance certificate has been issued evidencing coverage under the Policy and this Certificate.

Child means the Covered Person's natural Child, adopted Child (or Child placed in the Covered Person's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Covered Person has legal guardianship (proof will be required). A Child must reside with the Covered Person in a parent-Child relationship and be eligible to be claimed as an exemption on the Covered Person's federal income tax return. NOTE: In the event the Covered Person shares physical custody of the Child with another parent, the requirement that the Child reside with the Covered Person will be waived.

Civil Union Partner: The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded to spouses. Throughout the Policy and this Certificate, a party to a civil union shall be included in any definition or use of the terms such as spouse, family, , dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms ‘marriage’ or ‘married’ or variations thereon. The term spouse or dependent includes civil union couples whenever used.

“Company” means United States Fire Insurance Company. Also hereinafter referred to as We, Us and Our.

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 means an accidental death, dismemberment or other Injury covered under the Policy and this Certificate and indicated on the Schedule of Benefits.

"Covered Person" means an Insured Person and Dependent eligible for coverage as identified in the Enrollment/Application who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, for whom proper premium payment has been made when due, and who is therefore insured under the Policy and this Certificate.

"Deductible" means the dollar amount of Eligible Expenses which must be incurred and paid by the Covered Person before benefits are payable under the Policy and this Certificate. It applies separately to each Covered Person.
“Dependent” means a Covered Person’s:
1) lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner.
2) unmarried Children under age 26.
The age limitations will not apply to a Covered Person’s unmarried Child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

“Domestic Partner” means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Covered Person and shared financial assets/obligations with the Covered Person. Both the Covered Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

“Eligible Expenses” means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while the Policy and this Certificate is in force.

“He”, ”His” and ”Him” includes ”she”, ”her” and ”hers.”

“Health Care Plan” means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:
(1) Group or blanket insurance, whether on an insured or self-funded basis;
(2) Hospital or medical service organizations on a group basis;
(3) Health Maintenance Organizations on a group basis.
(4) Group labor management plans;
(5) Employee benefit organization plan;
(6) Professional association plans on a group basis; or
(7) Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
(8) Automobile no-fault coverage (unless prohibited by law).

“Hospital” means an institution which:
(1) Is operated pursuant to law;
(2) Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
(3) Is under the supervision of a staff of Physicians;
(4) Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
(5) Has medical, diagnostic and treatment facilities, with major surgical facilities;
   (a) On its premises; or
   (b) Available to it on a prearranged basis; and
(6) Charges for its services.

“Hospital” does not include:
(1) A clinic or facility for:
   (a) Convalescent, custodial, educational or nursing care;
   (b) The aged, drug addicts or alcoholics; or
   (c) Rehabilitation; or
(2) A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
   (a) The services are rendered on an emergency basis; and
   (b) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.
"Hospital Stay" means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

"Immediate Family" means a Covered Person's spouse, domestic partner, civil union partner, parent, Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws.

"Injury" means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Insured Person means a member of the Policyholder who is eligible and insured for coverage under the Policy and this Certificate and who is not a dependent.

"Leased Aircraft" means an aircraft for which the Policyholder or any of its subsidiaries or affiliates has a written lease under whose terms, the aircraft:
1. Can be used at the Policyholder's or any of its subsidiaries' or affiliates' discretion;
2. Can be used by the Policyholder or any of its subsidiaries or affiliates for 2 or more trips or for more than 10 consecutive days; and
3. Cannot be altered or sold by the Policyholder or any of its subsidiaries or affiliates, without the consent of the leaser or owner.

"Leased Aircraft" does not include any Owned Aircraft.

"Medically Necessary" or "Medical Necessity" means a treatment, service or supply that is:
1) required to treat an Injury;
2) prescribed or ordered by a Physician or furnished by a Hospital;
3) performed in the least costly setting required by the condition;
4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy or this Certificate.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

"Nurse" means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

"Occurrence" means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

"Operated or Controlled Aircraft" means an aircraft which:
(1) Has been leased, rented or borrowed by the Policyholder for at least 10 consecutive days, or more than 15 days in any one year;
(2) Can be used at the Policyholder's discretion; and
(3) Cannot be altered or sold by the Policyholder without the consent of the owner or leaser.

“Operated or Controlled Aircraft” does not include any Owned Aircraft.

“Owned Aircraft” means aircraft to which the Policyholder or any of its subsidiaries or affiliates holds legal or equitable title.

Physician means a person who is a qualified practitioner of medicine. As such, He or She must be acting within the scope of his/her license under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person's spouse, son, daughter, father, mother, brother or sister or other relative.

“Policyholder” means the entity shown as the Policyholder in the Schedule of Benefits.

“Prescription Drugs” means drugs which may only be dispensed by written prescription under Federal law, and reapproved for general use by the Food and Drug Administration.

“Rehabilitation Facility” means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. The facility may be either of the following:

(a) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or
(b) A free standing facility

“Sound Natural Teeth” means natural teeth, the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.

“Spouse” means lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Partner.

“Usual, Reasonable and Customary means:
(1) With respect to fees or charges, fees for medical services or supplies which are;
   (a) Usually charged by the provider for the service or supply given; and
   (b) The average charged for the service or supply in the locality in which the service or supply is received; or
(2) With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

We, Our, Us means United States Fire Insurance Company underwriting this insurance.

You, Your, Yours, He or She means the Covered Person who meets the eligibility requirements of the Policy and this Certificate and whose insurance under the Policy and this Certificate is in force.
ELIGIBILITY FOR INSURANCE

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

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 applicable, 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, He or She may be Covered only once under the Policy and this Certificate. In no event will a Dependent be eligible if the Insured Person is not eligible.

EFFECTIVE DATES OF INSURANCE:

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:
A Covered Person will become an insured under the Policy and this Certificate, provided proper premium payment is made, on the latest of:
(1) The Effective Date of the Policy; or
(2) The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form

Newborn Children Coverage: We will pay benefits for a newborn Child from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate.

Newborn Adopted Children Coverage:
In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by You prior to the birth of the Child, whether or not such agreement is enforceable.

Newborn Child Exception: This section does not apply to a newborn Child at that Child’s birth if the Child is born to You while You are insured as a Dependent under the Policy and this Certificate. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in Your home. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate.

Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child will be covered on the same basis as an adopted Child. There will be no enrollment restrictions placed on a Child in Court Ordered Custody and coverage will be effective immediately.
TERMINATION DATE OF INSURANCE:

Policy Termination Date
Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:
1) The Policy Termination Date shown in this Policy; or
2) The premium due date if premiums are not paid when due subject to any grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate this Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Covered Person's Termination Date

Insurance for a Covered Person under the Policy and this Certificate will end on the earliest of:

1) The Date the Policy Terminates;
2) The date He is no longer in an Eligible Class as described in the Policy;
3) The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
   (a) The date the premium is fully earned; or
   (b) The Expiration Date of the Certificate.
   This does not include Reserve or National Guard duty for training;
4) The end of the period for which the last premium contribution is made; or
5) The date the Covered Person requests, in writing, that his/her coverage be terminated.

Dependent’s Termination Date

A Dependent’s coverage under the Policy and this Certificate ends on the earliest of:
1) The date the Policy terminates; or
2) The date the Covered Person’s coverage ends; or
3) The date the Dependent is no longer a Dependent; or
4) The last day of the period for which premiums have been paid.
PREMIUM PROVISIONS

PREMIUMS:

The Company provides insurance in return for premium payments. The premium showed in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy or this Certificate with regard to change. Failure by the Policyholder or Certificateholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

The Company has the right to rely upon the accuracy of the Policyholder's calculations and to require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.

GRACE PERIOD:

A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Policyholder or certificate holder pays all the premiums due by the last day of the grace period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Policy and this Certificate. Coverage will end if the premium is not paid by the end of the grace period.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Covered Person's most recent address in Our records. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur:

1) A change in the terms of the Policy and this Certificate.
2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
3) A change in any federal or state law or regulation affecting the Policy and this Certificate and Our benefit obligation.
4) A change in the factors bearing on the risk assumed.
5) A misrepresentation in the information relied on in establishing the rate for the Policy and this Certificate
6) A change in the experience rating.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

Reinstatement

The Policy and this Certificate may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if the Policyholder or Certificateholder submits written application to the Company, the Company accepts the application and the Policyholder or Certificateholder makes payment of all overdue premiums.
SCOPE OF COVERAGE

We will provide the benefits described in the Policy and this Certificate to all Covered Persons who suffer a covered loss which:

(1) Is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and results, directly and independently of disease or bodily infirmity, from an Injury which is suffered in an Accident;

(2) Occurs while the person is a Covered Person under the Policy and this Certificate; and

(3) Is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

Terms of Payment for Benefits:

Full Excess Medical Expense:

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

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

(1) While the person is insured under this Certificate; or

(2) During the Benefit Period stated on the SCHEDULE OF BENEFITS.

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

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

DESCRIPTION OF HAZARDS

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

HAZARD #: 24 HOUR COVERAGE (except pilots, crew members and Owned Aircraft)

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

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

(1) He is riding as a passenger, and not as a pilot or member of the crew; and

(2) The Aircraft is not being used for:
(a) Crop dusting, spraying, or seeding; fire firefighting; sky writing; sky diving or hang gliding; pipeline or power line inspection; aerial photography or exploration; racing, endurance tests, stunt or acrobatic flying; or (b) Any operation which requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

**Aircraft Not Covered** - We will not pay benefits if the Aircraft is any of the following:

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

Unless otherwise stated, We will pay benefits for a covered loss, only once, even if coverage was provided under more than one Description of Hazards.

**DESCRIPTION OF BENEFITS**

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

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

<table>
<thead>
<tr>
<th>Loss</th>
<th>Percentage of Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of two or more Hands or Feet</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Speech and Loss of Hearing (both ears)</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Sight (both eyes)</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of one Hand or Foot</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Speech</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Hearing (both ears)</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Sight (one eye)</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of a thumb and index finger</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Loss of a hand or foot** means complete Severance through or above the wrist or ankle joint.

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

**Loss of speech** means total, permanent and irrecoverable loss of audible communication.

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

**Loss of a thumb and index finger** means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

"**Severance**" means the complete separation and dismemberment of the part from the body.
ACCIDENT MEDICAL EXPENSE BENEFITS

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

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

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

EXCLUSIONS

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

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
5. Participation in a riot or insurrection;
6. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
7. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an Accidental external bodily injury or accidental food poisoning.
8. Disease or disorder of the body or mind.
9. Mental or nervous disorders, except as specifically provided in this Certificate.
10. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person’s job.
11. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician and not taken in the dosage or for the purpose as prescribed by the Covered Person’s Physician.
12. Intoxication or being under the influence of any drug or narcotic
13. Injury caused by, contributed to or resulting from the Covered Person’s use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person’s Physician.
14. Driving under the influence of a controlled substance unless administered on the advice of a Physician;
15. Driving while Intoxicated. “Intoxicated” will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs
16. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
17. Conditions that are not caused by a Covered Accident.
18. Covered Expenses for which the Covered Person would not be responsible in the absence of this Certificate.
19. Any treatment, service or supply not specifically covered by this Certificate.
20. Charges which are in excess of Usual, Reasonable and Customary charges.
21. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
22. Regular health check ups;
23. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.

24. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);

25. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay

26. Participation in any motorized race or speed contest.

27. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.

28. Treatment of a hernia whether or not caused by a Covered Accident.

29. Treatment of Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological or stress fractures, congenital weakness, whether or not caused by a Covered Accident.

30. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.

31. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.

32. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Certificate.

33. Expense incurred for treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in this Certificate.

34. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Certificate, and rendered within 6 months of the Accident;

35. Treatment for Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;

36. Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;

37. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;

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

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

   Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.

40. Practice or play in any school or professional sports contest or competition.

41. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;

42. Rest cures or custodial care;

43. Prescription medicines unless specifically provided for under this Certificate.

44. Elective or Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;

45. Massage Therapy, Physical Therapy or Acupuncture/Acupressure Services, unless otherwise specifically allowed for in the schedule of benefits.

46. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of death or injury must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given at Our administrative office as shown on the cover page or to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
2) it is further shown that notice was given as soon as possible.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to Us in the case of a claim for loss for which this Certificate provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

1) it can be shown that it was not possible within reason to submit notice within the 90-180 day period; and
2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS:

Benefits due under this Certificate for a loss, other than a loss for which this Certificate provides installments, will be paid immediately upon receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which this Certificate provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

PAYMENT OF CLAIMS:
All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Certificate.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Certificate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Covered Person’s death may, at Our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

**DESIGNATION OR CHANGE OF BENEFICIARY:**

Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

1) Beneficiaries designated in writing by the Covered Person for this Certificate on file with the Policyholder, if any, otherwise;
2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
3) In equal shares to the members of the first surviving class of those that follow, if any:
   a) a Covered Person’s lawful spouse, if not legally separated or divorced, or Domestic Partner;
   b) a Covered Person’s natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
   c) a Covered Person’s parents, whether natural, step or adoptive; or
   d) a Covered Person’s Sisters or Brothers, otherwise.
4) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent’s beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent’s death, the beneficiary is the Covered Person’s estate.

**CONDITIONAL CLAIM PAYMENT:**

If a Covered Person incurs expenses for Injuries received in a covered Accident, and in Our opinion a third party may be liable, We will pay benefits if:

1. The Covered Person first agrees in writing to refund the lesser of:
   a) The amount We actually paid for such expenses; or
   b) The amount actually received from the third party for such expenses; and
2. The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, prior to Our payment of benefits under this Certificate, if the third party's liability is satisfied in an amount less than the benefits payable under this Certificate, We will pay the difference.
EXPOSURE AND DISAPPEARANCE:

A Covered Person will be presumed to have died due to covered injuries, if while insurance is in effect He suffers Covered Loss due to exposure to the elements.

A Covered Person will be presumed to have died, if, while insurance is in effect and after the forced landing, stranding, sinking or wrecking of a covered vehicle:

1) He disappears; and
2) His body is not found within a year of the Accident; and
3) a valid death certificate or other legal proof of death is issued by a court of appropriate jurisdiction.

PHYSICAL EXAMINATION AND AUTOPSY:

We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT:

If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods.
1) A request for lump sum payment of the amount overpaid or paid in error or
2) Reduction of any proceeds payable under this Certificate by the amount overpaid or paid in error.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Covered Person any benefits We have paid to him for injuries:
(1) Received in a covered Accident; and
(2) Which are covered under:
   (a) workers’ compensation or similar statutory remedies available under law; or
   b) Any employer's liability Insurance.

It will be assumed that the Covered Person is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

“Recovery” means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

SUBROGATION:

If We have paid benefits to a Covered Person for Injuries received in a covered Accident, and in Our opinion a third party may be liable, We will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents.
LEGAL ACTIONS:

All Policy terms will be interpreted under the laws of the state in which the Policy and this Certificate was issued. No legal action may be brought to recover on the Policy and this Certificate within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Policy, this Certificate, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured will also be made a part of this contract.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Covered Person’s effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in the Policy or this Certificate will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy and this Certificate. No agent may change the Policy or this Certificate or waive any of its provisions.

WORKERS’ COMPENSATION INSURANCE:

The Policy and this Certificate is not in lieu of and does not affect any requirement for coverage under any Workers’ Compensation Insurance.

RECORDS MAINTAINED:

The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person’s insurance under the Policy and this Certificate.

We shall be permitted to examine the Policyholder’s records relating to coverage under this Certificate. Examination may occur at any reasonable time up to the later of:

(1) The two year period after the expiration of the Policyholder’s coverage; or
(2) The final adjustment and settlement of all claims under the Policyholder’s coverage.

REPORTING REQUIREMENTS:

The Policyholder or its authorized agent must report to us, by the premium due date:

(1) The names of all persons insured on the Effective Date of this Certificate;
(2) The names of all persons who are insured after the Effective Date of the Policy and this Certificate;
(3) The names of those persons whose insurance has terminated; and
(1) Additional information required as agreed to by us and the Policyholder.
CERTIFICATES OF INSURANCE:

A certificate of insurance will be delivered to the Policyholder for delivery to each Covered Person. Each certificate will list the benefits, conditions and limits of the Certificate. It will state to whom the benefits will be paid.

POLICY TERMINATION:

We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

CONFORMITY WITH STATE STATUTES:

Any provision of the Policy and this Certificate in conflict on its effective date with the laws of the State of Issue indicated on the front page of the Policy and this Certificate is amended to conform to the minimum requirements of such laws.

OTHER COVERAGE WITH US:

At any one time each Covered Person may have only one Certificate issued by Us having coverage similar to that described in the Policy and this Certificate. If we find He has more than one such Certificate, coverage will be provided under the plan that has been in force for the longer period of time. We will refund premiums paid for all other Certificates for concurrent periods of coverage.

CLERICAL ERROR:

Clerical error 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:

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.

INSOLVENCY:

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Policy and this Certificate.

NON-PARTICIPATING:

The Policy and this Certificate is non-participating. It does not share in the Company's profits or surplus earnings.

WAIVER:
Failure of the Company to strictly enforce its rights under the Policy and this Certificate at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.
When used throughout this document “Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we’ve made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don’t have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

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

Grievance

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

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

Second Level Review

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

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

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

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

The panel must be comprised of persons who:

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

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

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.
We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

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

**EXPEDITED REVIEW**

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

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

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.
PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

• Insurance companies;
• Insurance agencies;
• Third party administrators;
• Medical bill review companies; and
• Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Fairmont Speciality
5 Christopher Way, 3rd Floor
Eatontown, New Jersey 07724
NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE OHIO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Section 3956.18(B)(1) of the Ohio Insurance Code requires all Group Life and Health insurers to provide a summary of the basic provisions of the Ohio Life and Health Insurance Guaranty Association Act.

Any questions concerning this summary should be directed to the Ohio Life and Health Insurance Guaranty Association or to the Ohio Insurance Department at the address below.

NOTICE
Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. HOWEVER, INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE GUARANTY ASSOCIATION TO INDUCE YOU TO PURCHASE ANY KIND OF INSURANCE POLICY.

The Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, Ohio 43220

Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43268-0588

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law’s coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone’s rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE
Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.
EXCLUSIONS FROM COVERAGE
However, persons holding policies are not protected by this association if:
- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:
- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. The association will not pay more than $100,000 in cash surrender values, $500,000 in major medical insurance benefits, $300,000 in disability or long-term care insurance benefits, $100,000 in other health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the association will pay a maximum of $300,000, except for coverage involving major medical insurance benefits, for which the maximum of all coverages is $500,000.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§401, 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.
Group Certificate

This is a health insurance Certificate. It pays a lump sum benefit for a Critical Illness, as defined in the Group Policy and this Certificate. The attached Enrollment Application is part of the Certificate. Please read and check it carefully. This Certificate is issued on the basis that your answers are correct and complete. If it is not complete or has an error, please let us know immediately. An incorrect application may cause your coverage to be voided, or a claim to be reduced or denied.

This Certificate describes the principal provisions of, but does not constitute the contract of insurance. The actual contract, referred to as the Group Policy, is available for inspection at the office of the Group Policyholder during regular business hours. The Group Policy Number and the name and address of the Group Policyholder are shown in the Certificate Schedule.

In this Certificate, Windsor Life Insurance Company is called “the Company”, “we”, “our”, “ours”, or “us”. The insured persons (Association members and their Spouses) are “you”, “your”, or “yours”. Capitalized terms used in this Certificate that are not proper names or section titles have the express meaning set forth in the Definitions sections of this Certificate.

Please read this Certificate carefully. It contains DEFINITIONS, BENEFITS, EXCLUSIONS, and LIMITATIONS.

Secretary

President

Form # WL-BLCI-001006-GROUP CERTIFICATE-2016-09-01
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## Sample Certificate Schedule

### Critical Illness Benefit Plan

<table>
<thead>
<tr>
<th>INSUREDS:</th>
<th>PLAN SPECIFICATIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY INSURED: MARY J. DOE</td>
<td>- Critical Illness Benefit: maximum of $2,500 per Covered Insured at issue</td>
</tr>
<tr>
<td>DATE OF BIRTH: October 18, 1978</td>
<td></td>
</tr>
<tr>
<td>EFFECTIVE DATE OF COVERAGE: September 1, 2016</td>
<td>- Benefit may increase, subject to the conditions contained in the &quot;Benefit Provisions&quot; section of this Certificate.</td>
</tr>
<tr>
<td>SPOUSE: JOHN H. DOE</td>
<td></td>
</tr>
<tr>
<td>DATE OF BIRTH: May 2, 1974</td>
<td>- At no time will the Critical Illness Benefit exceed $25,000 per Covered Insured</td>
</tr>
<tr>
<td>EFFECTIVE DATE OF COVERAGE: September 1, 2016</td>
<td></td>
</tr>
<tr>
<td>CERTIFICATE NUMBER: 012345</td>
<td></td>
</tr>
<tr>
<td>GROUP POLICYHOLDER: UNITED BUSINESS ASSOCIATION</td>
<td></td>
</tr>
<tr>
<td>GROUP POLICY NUMBER: WL-BLCI-001006</td>
<td></td>
</tr>
<tr>
<td>GROUP POLICYHOLDER'S ADDRESS: 409 West Vickery, Fort Worth, Texas 76104</td>
<td></td>
</tr>
<tr>
<td>BENEFICIARY FOR PRIMARY INSURED: SELF</td>
<td></td>
</tr>
<tr>
<td>BENEFICIARY FOR SPOUSE: SELF</td>
<td></td>
</tr>
<tr>
<td><strong>In this Certificate:</strong></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>---</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>means, on the Effective Date of Coverage, your age on your last birthday. Your Age increases one year on each Coverage Anniversary. For purposes of this Certificate, this age increase always occurs on the Coverage Anniversary even if your actual birthday occurs (as in most cases) during the Coverage Year prior to the Coverage Anniversary.</td>
</tr>
<tr>
<td><strong>Association</strong></td>
<td>means the same as the Group Policyholder. This is the entity to which you applied and became a member and through which you are eligible for this coverage.</td>
</tr>
<tr>
<td><strong>Beneficiary</strong></td>
<td>means the person or entity who receives the benefit if we receive notice that you are not living on the date we pay the benefit. (Otherwise, the benefit is paid to directly to you.) This is explained in the “Payment of Benefit” section below.</td>
</tr>
<tr>
<td><strong>Certificate</strong></td>
<td>means the written description of coverage provided to you that explains your coverage under the Group Policy.</td>
</tr>
<tr>
<td><strong>Coverage Anniversary</strong></td>
<td>means any anniversary of your Effective Date of Coverage.</td>
</tr>
<tr>
<td><strong>Coverage Year</strong></td>
<td>means the 12 month period ending on any Coverage Anniversary.</td>
</tr>
<tr>
<td><strong>Covered Insured</strong></td>
<td>means the Primary Insured or Spouse insured under the Group Policy. In this Certificate, “Covered Insured” has the same meaning as “you”.</td>
</tr>
<tr>
<td><strong>Critical Illness</strong></td>
<td>means one of the diseases or conditions in the section “Critical Illness: Definition and Diagnosis” for which positive diagnosis is made by a Physician, subject to the Requirements of Diagnosis set out in the section “Critical Illness: Definition and Diagnosis”.</td>
</tr>
<tr>
<td><strong>Effective Date of Coverage</strong></td>
<td>means the date your coverage becomes effective, as shown in the Certificate Schedule or any attached endorsements. It is possible for a Spouse to have an Effective Date of Coverage later than the Primary Insured (if, for example, the Primary Insured marries after the date his own coverage took effect).</td>
</tr>
<tr>
<td><strong>Enrollment Application</strong></td>
<td>means the application which you completed to become a member in the Association. The Enrollment Application is attached to and made a part of this contract.</td>
</tr>
<tr>
<td><strong>First Occurs or First Occurrence</strong></td>
<td>means the date you were positively diagnosed by a Physician as having a Critical Illness for the first time.</td>
</tr>
<tr>
<td><strong>Group Policy</strong></td>
<td>means the contract issued to the Group Policyholder providing the benefits described.</td>
</tr>
<tr>
<td><strong>Group Policyholder</strong></td>
<td>means the entity in whose name the group insurance contract (&quot;Group Policy&quot;) is issued.</td>
</tr>
<tr>
<td><strong>Immediate Family Member</strong></td>
<td>means your spouse, parent, son, daughter, brother, sister, grandchild, or any family member related to you by marriage.</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>means a licensed physician or other practitioner of the healing arts who is practicing within the scope of his license. An Immediate Family Member is not considered a Physician.</td>
</tr>
<tr>
<td><strong>Primary Insured</strong></td>
<td>means the active member of the Association to whom the Certificate is issued.</td>
</tr>
<tr>
<td><strong>SECTION 2 – DEFINITIONS</strong></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Spouse</strong></td>
<td></td>
</tr>
<tr>
<td>means a Primary Insured’s lawful spouse. The term “Spouse” shall include only the person to whom the Primary Insured is married, and whose marriage has been licensed, solemnized and registered in accordance with the statutory law of the jurisdiction in which the marriage occurred. In the case of a common law spouse, the Company requires a “Declaration and Registration of Informal Marriage” issued by a county clerk in the resident county, and signed by the eligible Primary Insured and the spouse attesting to the fact that a common law marriage relationship exists.</td>
<td></td>
</tr>
<tr>
<td><strong>The Company, We, Our, Ours, or Us</strong></td>
<td></td>
</tr>
<tr>
<td>refers to WINDSOR LIFE INSURANCE COMPANY.</td>
<td></td>
</tr>
<tr>
<td><strong>You, Your or Yours</strong></td>
<td></td>
</tr>
<tr>
<td>refers to the person or persons who are covered under this Certificate. “You”, “your” and “yours” apply to all Covered Insureds equally. When this Certificate wishes to refer specifically to only the Primary Insured or only the Spouse, it uses the terms “Primary Insured” or “Spouse”.</td>
<td></td>
</tr>
<tr>
<td>SECTION 3 – GENERAL PROVISIONS</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Eligibility for Insurance</strong></td>
<td>All active members of the Association and their Spouses, as set forth in the Group Policy, are eligible for coverage, subject to the following age restriction: coverage is only available to individuals between the ages of 18 and 64, inclusive.</td>
</tr>
</tbody>
</table>
| **When Coverage Starts** | Your coverage starts at 12:01 a.m., Standard Time, at your home on your Effective Date of Coverage. Your Effective Date of Coverage can be found in the Certificate Schedule.  
If a Primary Insured marries while an active member of the Association, coverage for the Spouse begins on the 1st of the month following the date the Spouse is recognized as such by the Association, subject to the Association’s guidelines.  
Each Covered Insured should be listed in the Certificate Schedule, along with the appropriate Effective Date of Coverage. **It is your responsibility to provide the Association with information on any changes in marital status that would affect your insurance coverage.** It is the Association’s responsibility to provide to you updated Certificate Schedules or endorsements reflecting any changes in coverage. |
| **When Coverage Stops** | The insurance provided under your Certificate will terminate with regard to a specific Covered Insured (coverage for other Covered Insureds, if any, will remain in force) on the earliest of the following dates:  
- the date the Covered Insured reaches Age 65;  
- the date a Benefit is paid to that Covered Insured;  
- the date the Covered Insured dies;  
and, in addition:  
- with respect to Spouses, the date the Spouse is no longer considered the spouse of an active member of the Association, subject to the Association’s guidelines.  
The insurance provided under your Certificate will terminate for all Covered Insureds simultaneously on the earliest of the following dates:  
- the date the Primary Insured is no longer considered an active member of the Association, subject to the Association’s guidelines;  
- the date the Primary Insured dies;  
- the date the Group Policy terminates.  
A valid claim will still be considered for payment after the date coverage terminates, as long as it First Occurred while your coverage was still in force. |
| **Renewable at the Option of the Company** | We will renew your Certificate as long as: (1) the Group Policy remains in force; and (2) you remain a member of the Association, subject to the Association’s guidelines. |

<table>
<thead>
<tr>
<th>SECTION 4 – PREMIUM PAYMENT PROVISIONS</th>
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</thead>
<tbody>
<tr>
<td><strong>No Premiums Payable by You</strong></td>
</tr>
</tbody>
</table>
### SECTION 5 – BENEFIT PROVISIONS

| Critical Illness Benefit Amount | We pay a benefit if you are diagnosed as having a Critical Illness for the first time. We pay this benefit only if the Critical Illness First Occurs after your Effective Date of Coverage and while your coverage under this Certificate is in force. We pay the Critical Illness Benefit only one time, regardless of the subsequent occurrence of the same or different Critical Illness affecting you. It is a lump sum benefit. Once the benefit is paid, coverage for you alone under the Certificate terminates. (Coverage for your spouse, if any, will remain in force.)

The benefit is paid as follows:

- If you have been insured under this Certificate for less than 12 continuous months following your Effective Date of Coverage and immediately prior to the First Occurrence of a Critical Illness, the Critical Illness Benefit is $2,500.

- If you have been insured under this Certificate for at least 12 continuous months following your Effective Date of Coverage and immediately prior to the First Occurrence of a Critical Illness, the Critical Illness Benefit is $25,000.

| Notice of Claim | You must notify us within 30 days after a covered loss occurs or starts, or as soon as possible. Notice is sent to our home office (for the address, refer to the Certificate Signature Page or any attached endorsements). All notices should always include the Covered and Primary Insured’s name(s), current address, and Certificate number.

| Claim Forms | When we receive a notice of claim, we send forms for filing proof of loss. If we do not do so within 15 days, you should submit in writing the nature and extent of the loss. The statement should be sent within the time noted for Proof of Loss. Claim forms may also be requested from Windsor Life Insurance Company at { (877) ENTEXAS}.

| Proof of Loss | Written proof must be given within 90 days after the loss or as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless you were legally unable to do so.

| Examination of Hospital or Physician Records | We may, at our expense, examine your hospital and Physician records as often as reasonably necessary while a claim is pending.

| Physical Examination and Autopsy | When a claim is submitted, we have the right to have you examined as often as reasonably necessary. In case of death, we have the right to have an autopsy performed where it is not forbidden by law. We pay all expenses for these procedures.

### SECTION 6 – PAYMENT OF BENEFIT

| Lump Sum | We will pay the Critical Illness Benefit in a lump sum, unless otherwise agreed. The benefit is paid directly to you. Any benefit unpaid when you die is paid to your Beneficiary. Your chosen Beneficiary is indicated in the Certificate Schedule.

| Interest on Payment | A lump sum payment is made immediately when we get written proof of loss. We will add interest to our lump sum payment, figured from the date of your loss until the date of our payment. The interest will be calculated at a rate of 3% per year, or if greater, at the interest rate, if any, required by law in the state where the Group Policy was issued. |
**SECTION 6 – PAYMENT OF BENEFIT**

| **Beneficiary** | The Critical Illness Benefit provided under the Certificate is payable to you unless otherwise designated by you. Should you die before the settlement of a pending claim under your Certificate, the amount of the claim is payable to the designated Beneficiary of your Certificate. Such designation must be in writing to us and, once we acknowledge receipt of your written notice, will be effective on the date it was signed by you.

If you have designated a Beneficiary, his or her name will appear in your Certificate Schedule. If there is no named Beneficiary, the benefit is paid:

1. to your living lawful spouse; or
2. if you do not have one, in equal shares to your living lawful children; or
3. if there are none, in equal shares to your living lawful parents; or
4. if there are none, in equal shares to your living lawful brothers and sisters; or
5. if there are none, to your estate.

Spouse means only the one to whom you were lawfully married on the date of your death. (See definition of “Spouse” in the Definitions section for further clarification.)

Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean “step” children, parents, brothers or sisters.

| **Change of Beneficiary** | Unless you indicate that a Beneficiary cannot be changed, you can change the Beneficiary at any time. The Beneficiary’s consent is not needed. We will make the change only if we first acknowledge receipt of your written request to do so. It will take effect on the date the request was signed by you. The change is subject to: (1) the rights of any assignee; and (2) any payment made or action taken before our acknowledgement. |

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**SECTION 7 – CRITICAL ILLNESS: Definition and Requirements of Diagnosis**

| **Critical Illness: Definition** | The following Critical Illnesses must also meet the criteria established in the Requirements of Diagnosis section:

| **Life-Threatening Cancer** | Life-Threatening Cancer includes only those types of cancer manifested by the presence of a malignant tumor, characterized by the uncontrolled growth and spread of malignant cells that invade tissue, blood or the lymphatic system. As used herein, Leukemia and Hodgkin’s Disease (except Stage I Hodgkin’s Disease) shall be considered Life Threatening Cancer.

Life Threatening Cancer does not include: 1) premalignant tumors or polyps; 2) cancer in situ; 3) carcinoid of the appendix; 4) Stage 0 transitional carcinoma of urinary bladder; or 5) any skin cancers other than malignant melanomas.

| **Heart Attack** | Heart Attack means an acute myocardial infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more of the coronary arteries and resulting in the loss of normal function of the heart.

| **Stroke** | Stroke means an acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least thirty (30) days. This definition of Stroke shall specifically exclude transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits. |
### SECTION 7 – CRITICAL ILLNESS: Definition and Requirements of Diagnosis

#### Critical Illness: Requirements of Diagnosis
We must be furnished in writing a diagnosis of conditions by a Physician. This diagnosis must include documentation supported by clinical, radiological, histological, or laboratory evidence of the condition. We may require at our expense an additional examination by a Physician of our choice.

#### Life-Threatening Cancer
Life-Threatening Cancer must be positively diagnosed by a Physician certified by the American Board of Pathology to practice Pathologic Anatomy, or a certified Osteopathic Pathologist. Diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or post-mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. Clinical diagnosis alone will not meet this standard.

#### Heart Attack
The diagnosis of a Heart Attack must be made by a Physician board-certified in Cardiology and based on both of
1. New clinical presentation and/or electrocardiographic changes consistent with an evolving heart attack; and
2. Serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a diagnosis of heart attack.

Established (old) Myocardial Infarction is excluded.

#### Stroke
The diagnosis of a Stroke must be made by a Physician board-certified in Neurology.

### SECTION 8 – LIMITATIONS & EXCLUSIONS

#### Exclusions
We do not pay any benefits:
1. for a Critical Illness that First Occurs before your Effective Date of Coverage
2. if your coverage is not in force on the date the Critical Illness First Occurs
3. if the Certificate is not in force on the date the Critical Illness First Occurs
4. for any condition that is not diagnosed as a Critical Illness

#### Limitations
2. The Lifetime Maximum Certificate Benefit for each Covered Insured is $25,000

### SECTION 9 – OTHER INFORMATION

#### Pronouns
Masculine pronouns also refer to the feminine gender unless stated otherwise.

#### Misstatement of Age
If your Age is incorrectly stated, then
1. If your Certificate would not have been issued had you correctly stated your Age, the Certificate is treated as if it never existed. No benefits are paid.
2. If your coverage would have stopped if you had correctly stated your Age, no benefits will be paid for a Critical Illness that First Occurred after the date coverage would have stopped.
### Incontestability
Certificates issued under this Group Policy are incontestable with respect to a particular Covered Insured after coverage has been in force for two (2) years from the Effective Date of Coverage for that Covered Insured. Only a statement contained in a written instrument signed by the Primary or Covered Insured and attached to this Certificate can be used to contest validity of the Certificate.

All of your statements are considered representations and not warranties.

### Alternative Dispute Resolution
If you and the Company do not agree on the diagnosis (as defined in the contract), either may request the opinion of a Medical Referee at our expense. Such a request must be submitted in writing and must include a description of the issue disagreed upon. If it is mutually acceptable to pursue the opinion of a Medical Referee, each party shall select a Physician and shall notify the other party of the Physician chosen.

Each Physician will examine you and your medical records.

If the two Physicians are unable to agree, they will appoint a disinterested third Physician acceptable to both to act as the Medical Referee.

Such Medical Referee must be a board-certified specialist in the medical field pertinent to the issue disputed. The Medical Referee shall meet with the other two Physicians, if necessary, at a mutually agreed upon time and place in an attempt to resolve the differences.

If the decision of the Medical Referee is in your favor, the Company will accept the decision as binding and pay the cost of your Physician, the Company’s Physician and the Medical Referee.

If the decision is in favor of the Company, the Company will pay the cost of its Physician and the Medical Referee (but not the cost of your Physician). However, a decision in favor of the Company is not binding on you, and you may appeal further as provided by law.

### Agency
For all intents and purposes under this Group Policy, the Group Policyholder acts on its own behalf or as an agent of each Covered Insured. Under no circumstances will the Group Policyholder be deemed an agent of Windsor Life Insurance Company.

### Certificates
It is the responsibility of the Group Policyholder to deliver to you this Certificate describing the principal terms of your coverage.

Changes to the Covered Insureds (such as addition or deletion of a Spouse) and their Effective Dates of Coverage will be indicated in the Certificate Schedule and updated Schedules or endorsements will be provided to you by the Group Policyholder.

The Group Policyholder will attach to this Certificate a copy of your Enrollment Application and any written correspondence signed by you pertaining directly to requests for coverage of a Spouse (such as those including the Spouse’s name, age or date of birth).

### Conformity
Any provision of the Group Policy or this Certificate which, on your Effective Date of Coverage, is in conflict with the statutes of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such statutes.

### Entire Contract
The Group Policy, the Group Policyholder’s application, your Certificate, the attached Enrollment Application, and any attached papers or endorsements constitute the entire contract. No change in the Certificate is effective unless approved in writing by one of our officers. The approval must be noted on or attached to the Certificate. No agent may change the Certificate or waive any of its provisions.
INVESTORS HERITAGE LIFE INSURANCE COMPANY
200 Capital Avenue, Frankfort, KY 40601
(800) 422-2011
(Referred to in the Group Policy as the Company, We, Us, Our)

CERTIFICATE OF INSURANCE

We agree to pay the benefits provided by the Group Policy according to all its conditions and provisions.

This Certificate describes the principal provisions of, but does not constitute the entire contract of insurance. The entire contract of insurance is available for inspection at the Home Office of the Company.

This Certificate replaces any previous Certificate issued to You for the insurance described in this Certificate. All benefits are subject in every way to the entire Group Policy.

Signed for the Company at Frankfort, Kentucky on the Certificate Effective Date by:

President     Secretary

GROUP TERM LIFE INSURANCE CERTIFICATE
Non-Participating
Non-Contributory
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SCHEDULE OF BENEFITS

Group Policyholder: United Business Association
Group Policy Number: 4G0400
Certificate Number: [GC-001]
Certificate Effective Date: [07/01/13]
Insured Member: [John Doe]
Eligible Class: [Association Member]
Insured Member’s Beneficiary: [Jane Doe]
Dependent Spouse Life Insurance: [Yes; No]
Insured Dependent Spouse (if applicable): [Jane Doe]
Insured Dependent Spouse’s (if applicable) Beneficiary: [John Doe]

AMOUNT OF MEMBER INSURANCE

<table>
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<th>Class</th>
<th>Life Insurance</th>
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<tr>
<td>All Members</td>
<td>$10,000</td>
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</tbody>
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AMOUNT OF DEPENDENT SPOUSE INSURANCE *

<table>
<thead>
<tr>
<th>Class</th>
<th>Life Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Eligible Dependent Spouses of All Insured Members under a family plan of the Association</td>
<td>$10,000</td>
</tr>
</tbody>
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*In no event will the amount of the Insured Dependent Spouse Insurance exceed the amount of the Insured Member’s Insurance.
DEFINITIONS

Certain words or phrases, when used in this Certificate of Insurance, have only the meanings shown below. When a defined word or phrase is used, it is capitalized to indicate that it has been defined. The definitions are listed in alphabetical order.

**Association** means United Business Association to which the Group Policy is issued and named as the Group Policyholder on the Schedule of Benefits of this Certificate of Insurance.

**Beneficiary** means the person or persons named in writing by the Insured Person to receive the life insurance benefits and accidental death benefits.

**Eligible Member** means a person who is at least 18 years of age and a member in good standing of the Association.

**Eligible Dependent Spouse** means the Insured’s lawful spouse, including a legally separated spouse, residing in the United States and a named member of the Association under a family plan. The Insured Member may not insure his or her spouse if the spouse is enrolled for insurance under the Group Policy as an Insured Member. (Spouse, wherever used, includes domestic partner. Domestic partner is the person named in the Insured’s declaration of domestic partnership. The Insured Member must execute and provide the Group Policyholder with such a declaration which states and gives proof that the domestic partnership meets the requirements of the State in which the Insured Member and the domestic partner reside.)

**Insured Member, You** means the Eligible Member who is insured under the Group Policy.

**Insured Dependent Spouse** means the Eligible Dependent Spouse who is insured under the Group Policy.

**Insured Person** means the Insured Member and his or her Insured Dependent Spouse who are insured under the Group Policy.

**Group Policy** means the Group Policy issued to the Group Policyholder.

**Group Policyholder** means the Association named as the Group Policyholder on the Schedule of Benefits of this Certificate of Insurance.
CONDITIONS FOR INSURANCE

ELIGIBILITY FOR INSURANCE

The Schedule of Benefits shows the Eligible Class for Eligible Members. A person is an Eligible Member on the date he or she becomes a member in good standing of the Association.

The Schedule of Benefits shows the Eligible Classes for Eligible Dependent Spouses. If Dependent Spouse life insurance is applicable to Your Eligible Class and You have elected this benefit as shown on the Schedule of Benefits, Your spouse is an Eligible Dependent Spouse on the date You are eligible.

WHEN INSURANCE STARTS

Eligible Members are insured on the date he or she becomes an Eligible Member. This is the Certificate Effective Date as shown on the Schedule of Benefits.

An Eligible Dependent Spouse is insured on the date the Insured Member's insurance becomes effective. If the Insured Member does not have an Eligible Dependent Spouse on the date his or her insurance becomes effective, insurance for an Eligible Dependent Spouse of the Insured Member will become effective on the date the Insured Member acquires an Eligible Dependent Spouse.

WHEN INSURANCE ENDS

Insurance for an Insured Member will end automatically on the earliest of the following dates:

1. The date the Insured Member is no longer a member in good standing of the Association;
2. The date the Insured Member reaches age 65; or
3. The date the Group Policy ends.

Insurance for an Insured Dependent Spouse will end automatically on the earliest of the following dates:

1. The date the Insured Member’s insurance ends;
2. The date the Insured Dependent Spouse is no longer an Eligible Dependent Spouse as defined; or
3. The date the Eligible Dependent reaches age 65.

INCONTESTABILITY

The validity of this Group Certificate shall not be contested except for nonpayment of premiums after it has been in force for two years from the Certificate Effective Date.

Statements made by any person insured may not be used to contest the Insured Person’s insurance unless:

1. The insurance has been in force for less than two years during the Insured Person’s lifetime;
2. The statement is in written form signed by the Insured Person; and
3. A copy of the form which contains the statement is given to the Insured Person or the Insured Person’s Beneficiary at the time insurance is contested.
INSURED MEMBER LIFE INSURANCE

Life Insurance Benefit
We will pay the Amount of Member Life Insurance shown in the Schedule of Benefits to Your Beneficiary upon receipt of due proof of death.

Suicide Exclusion
If the Insured Member's death is due to suicide, while sane or insane, within two years from the Certificate Effective Date, We will only pay a benefit equal to the premium paid.

Conversion Privilege
When Your Life Insurance ceases, You may apply to Us for an individual life policy (called the Converted Life Policy). A Converted Life Policy will be issued if You are Eligible to Convert, and You apply in writing and pay the first premium for the Converted Life Policy to Us within 31 days after the date Your Life Insurance ceases. Evidence of insurability is not needed.

Insured Members Eligible to Convert
You are Eligible to Convert Your Life Insurance only if:

1. Your insurance ceases due to no longer being a member in good standing of the Association; or
2. The Group Policy is cancelled for the Class of insureds to which You then belong and You have been insured under the Group Policy for at least five years before it is cancelled.

Converted Life Policy
The amount that You may convert when You lose Your Life Insurance will not be more than the amount of Your Life Insurance which terminates at that time. If all insurance under the Group Policy is cancelled on the Class of insureds to which You belong, the amount of insurance under the Converted Life Policy will not be more than the smaller of:

1. The amount of Your insurance which ceases less any amount of group life insurance for which You become eligible within 31 days after the insurance ceases; or
2. $10,000.

The Converted Life Policy will be one of the Company's current offerings based on its rules for Converted Life Policies. It will be issued at Your attained age for the premium that applies to the class of risk to which You then belong and will take effect on the 32nd day after the date Your Life Insurance ceases. Neither term insurance nor disability benefits are offered under the Converted Life Policy.

Payment During the 31-Day Conversion Period
If You die during the 31 days in which You may convert Your Life Insurance, We will pay Your Beneficiary the amount of insurance which You could have converted. In this case, no payment will be made under a Converted Life Policy.

INSURED DEPENDENT SPOUSE LIFE INSURANCE

Life Insurance Benefit
If Dependent Spouse Life Insurance is shown as applicable to Your Class and You have elected this benefit as shown on the Schedule of Benefits, We will pay the Amount of Dependent Spouse Life
Insurance shown on the Schedule of Benefits to You upon receipt of proof of the Dependent Spouse’s death.

**Suicide Exclusion**
If the Insured Dependent Spouse’s death is due to suicide, while sane or insane, within two years from his or her effective date of coverage under this Certificate, We will only pay a benefit equal to the premium paid for the Insured Dependent Spouse’s insurance.

**Conversion Privilege**
When an Insured Dependent Spouse’s Life Insurance ceases, such Insured Dependent Spouse may apply to the Company for an individual life policy (called the Converted Life Policy). A Converted Life Policy will be issued to an Insured Dependent Spouse who is Eligible to Convert if he or she applies in writing and pays the first premium for the Converted Life Policy to the Company within 31 days after the date the Life Insurance ceases. Evidence of insurability is not needed.

**Dependents Eligible to Convert**
An Insured Dependent Spouse is Eligible to Convert only if:

1. The Insured Dependent Spouse’s Life Insurance ceases because the Insured Member's insurance under the Group Policy ceases;
2. The Insured Dependent Spouse ceases to be an Eligible Dependent Spouse as defined; or
3. Dependent Spouse Life Insurance is cancelled for the class of Insured Members to which the Insured Member then belongs and the Insured Dependent Spouse has been insured under the Group Policy for at least five years before the insurance is cancelled.

**Converted Life Policy**
The amount of insurance under the Insured Dependent Spouse’s Converted Life Policy will not be more than the amount of that Insured Dependent Spouse’s Life Insurance which ceases. If all Insured Dependent Spouse’s Life Insurance is cancelled for the class of Insured Members to which the Insured Member belongs, the amount of insurance under the Insured Dependent Spouse’s Converted Life Policy will not be more than the smaller of:

1. The amount of the Insured Dependent Spouse’s insurance which ceases less any amount of group life insurance for which the Insured Dependent Spouse becomes eligible within 31 days after the insurance ceases; or
2. $10,000.

The Converted Life Policy will be one of the Company's current offerings based on its rules for Converted Life Policies. It will be issued at the Insured Dependent Spouse's attained age for the premium that applies to the class of risk to which the Insured Dependent Spouse then belongs and will take effect on the 32nd day after the date the Life Insurance for the Insured Dependent Spouse ceases. Neither term insurance nor disability benefits are offered under the Converted Life Policy.

**Payment During the 31-Day Conversion Period**
If the Insured Dependent Spouse dies during the 31 days in which he or she may convert his or her Life Insurance, the Company will pay You the amount of insurance which the Insured Dependent Spouse could have converted. In this case, no payment will be made under a Converted Life Policy.
**BENEFICIARY**

**Specifying the Beneficiary**
The Insured Member will designate a Beneficiary for Member Life Insurance. The Beneficiary designation must be made on a form which We provide or on a form acceptable to Us. The Insured Member may also designate a contingent Beneficiary. All Beneficiary designations will be filed with the Company or, if agreed to in advance by Us, with the Group Policyholder.

If two or more Beneficiaries are named, payment will be apportioned equally unless the Insured Member has specified otherwise. Unless otherwise provided by the Insured Member, if a Beneficiary dies before the Insured Member, We will divide that Beneficiary's share equally between any remaining named Beneficiaries. If no named Beneficiary survives the Insured Member or if no Beneficiary is designated by the Insured Member, We will pay the death benefits to the Insured Member’s estate.

If a Beneficiary is a minor or is not able to give Us a valid release for any payment of benefits made, We will not make a payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such Beneficiary. This provision does not prevent Us from making payment to or for the benefit of a minor Beneficiary in accordance with the applicable State law.

If Insured Dependent Spouse Life Insurance is shown as applicable to Your Class and You have elected this insurance as indicated on the Schedule of Benefits, You are the Beneficiary for Dependent Spouse Life Insurance unless otherwise specified in writing to Us by You.

**Change of Beneficiary**
The Insured Person may change his or her Beneficiary designation at any time. The change must be made on a form satisfactory to Us and signed by the Insured Person. No change of Beneficiary will take effect until this form is received by Us or by the Group Policyholder, if it has been agreed that Beneficiary designations be filed with the Group Policyholder. When this form is received, the change will take effect as of the date on the form. If the Insured Person dies before the form is received, We will not be liable for any payment that was made before receipt of the form.

**Consent of Beneficiary**
Consent of the Beneficiary will not be required to change the Beneficiary or to effect any other changes.

**PAYMENT OF DEATH PROCEEDS**

**Payment of Benefits**
All proceeds payable because of an Insured Person’s death will be paid to the Beneficiary no later than 2 months following the date We receive sufficient proof of death and the right of the claimant to the proceeds. Appropriate forms for giving Us proof of death will be made available to the Insured Person’s Beneficiary upon request. Benefits will be paid in a lump sum (cash) unless otherwise agreed.

Benefits for the loss of life of an Insured Dependent Spouse, will be paid to the Insured Member. If the Insured Member does not survive the Insured Dependent Spouse, any benefits for loss of life of the Insured Dependent Spouse will be paid to the executors or administrators of the Insured Dependent Spouse.
Interest on Payment
We will add interest to the death proceeds payable from the date of death until the date of Our payment at the rate then used by Us, which in no event will be less than the rate and method required by State law.

Protection of Proceeds
To the extent permitted by law, no payment of proceeds or interest will be subject to the claims of any creditors of the Beneficiary or to any legal process against the Beneficiary.

Facility of Payment
If any death benefits are to be paid to the estate of the Insured Person, We may pay an amount not greater than $250 to any person We consider to be equitably entitled by reason of having incurred funeral or other expenses incident to the Insured Person’s death. Any and all payments made by Us shall fully discharge Us in the amount of such payment.

Autopsy
We, at Our expense have the right to have an autopsy performed, unless it is prohibited by law.