

UNITED STATES FIRE INSURANCE COMPANY

Wilmington, Delaware

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

RIDER:

POLICY HOLDER: American Better Health Organization
POLICY NUMBER: US2093064
POLICY EFFECTIVE DATE: January 1, xxxx
POLICY TERMINATION DATE: December 31, xxxx
STATE OF ISSUANCE: STATE
RIDER EFFECTIVE DATE: January 1, xxxx

INVASIVE CANCER, CRITICAL ILLNESS BENEFITS RIDER

1. The following is added to the Schedule of Benefits:

Invasive Cancer, Critical Illness Benefits	
Maximum Benefit Amount	\$XXXX
Invasive Cancer	100% of the Maximum Benefit Amount
Heart Attack (Myocardial Infarction)	100% of the Maximum Benefit Amount
Major Organ Transplant	100% of the Maximum Benefit Amount
Stroke	100% of the Maximum Benefit Amount

2. We will pay the benefit shown in the Schedule of Benefits:

1. if the Covered Person is diagnosed for the first time by a Physician as having a Covered Condition and the diagnosis is made while the Coverage is in force; and
2. if the Covered Condition is not a Pre-Existing Condition; and
3. if the Covered Condition is first diagnosed after the Covered Person's Rider Effective Date; and
4. if none of the exclusions or limitations described in the Coverage or Policy apply; and
5. if the Covered Person signs up for coverage prior to Age 65; and
6. if the Covered Person is less than Age 70.

The benefit amount will be reduced as described below:

1. if the Covered Condition is first diagnosed within 365 days from the Covered Person's Rider Effective Date, We will pay \$ XXXX.

The following conditions are payable under this benefit rider. If a condition is not shown below, no benefits will be paid for that illness.

1. **Invasive 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 Invasive Cancer.

This does not include:

1. Skin cancer or melanoma that is not invasive.
2. All tumors of prostate unless the Gleason score is greater than 6 or having progressed to at

- least clinical TNM classification T2 N0 M0;
- 3. Cancer in situ;
- 4. Carcinoid of the appendix;
- 5. Stage 0 transitional carcinoma of the urinary bladder; or
- 6. Any other pre-malignant lesions, benign tumors, or polyps.

Invasive Cancer must be diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology and must be based on microscopic examination of fixed tissues or preparations from the hemic system. Such diagnosis shall be based solely on the accepted criteria of malignancy, after a study of the histocytologic architecture or pattern of the suspected tumor, tissue, and/or specimen. Clinical Diagnosis of Invasive Cancer will be accepted as evidence that Invasive Cancer exists when a Pathological Diagnosis cannot be made, provided the medical evidence substantially documents the Clinical Diagnosis of Invasive Cancer and the Covered Person receives treatment for Invasive Cancer.

2. **Heart Attack (Myocardial Infarction)** – 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. The Diagnosis of the 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.

3. **Major Organ Transplant** – is the receipt by transplantation of:

- a. human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation, or
- b. a whole human heart, lung, kidney, pancreas or liver due to irreversible end stage failure of such organ.

To qualify for the benefit amount:

1. the Covered Person must be registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing major organ; and
2. the need for major organ transplant must be first diagnosed after 180 days from the Rider Effective Date.

Major Organ Transplant does not mean:

- a. other stem cell transplant; or
- b. transplantation of only part of an organ.

4. **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.

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

DEFINITIONS For purposes of this rider:

Clinical Diagnosis means a clinical identification of Invasive Cancer or In-Situ Cancer based on history, laboratory study and symptoms.

Covered Condition means any of the coverages listed under the Schedule of Benefits for this Rider.

Diagnosis means the definitive establishment, acceptable to us, of the condition listed in this benefit rider through the use of clinical and/or laboratory findings and subject to the terms and conditions of the coverage. The Diagnosis must be made by a Physician who is a board-certified specialist where required under the terms of the coverage.

We reserve the right to request a Physician of our choice to review any Invasive Cancer, Critical Illness diagnosis in the event of a dispute or disagreement regarding the appropriateness or correctness of such diagnosis. We reserve the right to require the Covered Person to submit to an examination to confirm a disputed diagnosis. We also reserve the right to request that an independent and acknowledged expert in the applicable field of medicine review the evidence used in making any disputed diagnosis. We will pay for any such requested examination or review.

Pathological Diagnosis means an identification of cancer based on a microscopic study of fixed tissue or preparations from the hemi(blood) system.

Pre-existing Condition(s) means a condition for which medical advice, Diagnosis, care or treatment was recommended or received within the 3-month period before the Covered Person's Rider Effective Date. A Pre-Existing Condition is excluded from coverage for period of 6 months following the Covered Person's Rider Effective Date. If the Covered Person is Diagnosed with a condition listed in this rider that is determined to be a Pre-Existing Condition, no benefit amount is payable for that listed condition. We may have the Covered Person examined by a Physician of Our choosing at Our expense.

EXCLUSIONS In addition to the Common Exclusions listed in the Policy, no benefits will be paid for:

1. Benign tumors or polyps that are histological described as non-malignant, pre- malignant or non-invasive.
2. All skin cancers with the exception of invasive melanoma classified as Clark level II or higher or having a thickness measured in excess of .25mm.
3. All tumors of the prostate, unless having progressed to at least TNM classification T2 N0 M0 or histological classified as having a Gleason score greater than 6.
4. Chronic Lymphocytic Leukemia (CLL) unless Rai Stage 3 or greater.
5. Papillary micro invasive cancer of the thyroid, bladder, cervix or breast.
6. Participation in the commission or attempted commission of a felony.
7. Voluntary participation in a riot or insurrection.
8. Refusing certain types of recommended medical treatment as follows:
 - a. A Physician has recommended treatment with angioplasty or coronary artery bypass graft for coronary artery disease, the Covered Person refuses this treatment, and the Covered Person suffers a heart attack.
 - b. A Physician has recommended treatment for a brain aneurysm or carotid artery stenosis, the Covered Person refuses treatment, and the Covered Person suffers a stroke.
 - c. A Physician has recommended a diagnostic biopsy or diagnostic/therapeutic excision of a mass or lesion suspected of being cancerous, the Covered Person refuses, and the Covered Person develops cancer.
9. Conditions that have not been Diagnosed by a Physician.
10. Conditions that were diagnosed after the benefit rider has been terminated.
11. If the Covered Person's date of birth or age was misstated on the application and, using the correct date of birth or age, the benefit would not have become effective or would have terminated prior to Diagnosis of a listed condition.
12. Pre-existing Conditions.

PAYMENT OF BENEFITS In addition to the policy claim provisions, payment of the benefit amount is subject to all of the following conditions:

1. The sum of the benefit amounts payable under this benefit rider and any other Invasive Cancer, Critical Illness policy and Invasive Cancer, Critical Illness policies issued by Us on the life of the Covered Person may not exceed \$XXXX.
2. Only one benefit payment is allowed during the lifetime of the Covered Person, as defined by the terms and conditions of this benefit rider. After the payment is made to the Covered Person, this benefit will terminate for that particular Covered Person only.

Signed for **United States Fire Insurance Company** By:



Marc J. Adee
Chairman and CEO



Michael P. McTigue
Secretary

UNITED STATES FIRE INSURANCE COMPANY

Wilmington, Delaware
Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

GROUP BENEFITS – HOSPITAL FIXED INDEMNITY CERTIFICATE OF INSURANCE

POLICYHOLDER:	American Better Health Organization
POLICY NUMBER:	US2093063
POLICY EFFECTIVE DATE:	January 1, xxxx
POLICY EXPIRATION DATE:	December 31, xxxx
CERTIFICATE EFFECTIVE DATE:	January 1, xxxx
CERTIFICATE EXPIRATION DATE:	December 31, xxxx

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 STATE.

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. Adees
Chairman and CEO



Michael P. McTigue
Secretary

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SCHEDULE OF BENEFITS

POLICYHOLDER: American Better Health Organization

POLICY EFFECTIVE DATE: 1/1/xxxx

POLICY NUMBER: US2093063

PREMIUM DUE DATE: Monthly in advance on the 1st of each month

POLICY PERIOD: January 1, xxxx through December 31, xxxx

CERTIFICATE EFFECTIVE DATE: January 1, xxxx

CERTIFICATE EXPIRATION DATE: December 31, xxxx

CLASSES OF ELIGIBLE PERSONS:

Eligible Person is an individual who meets all of the requirements of one of the covered classes shown below:

Class 1 All active members of the Policyholder enrolled in memberships which include the benefits provided hereunder.

Class 2 All active members of the Policyholder enrolled in memberships which include the benefits provided hereunder, as well as their Spouse.

Class 3 All active members of the Policyholder enrolled in memberships which include the benefits provided hereunder, as well as their Dependent Child(ren).

Class 4 All active members of the Policyholder enrolled in memberships which include the benefits provided hereunder, as well as their Spouse and Dependent Child(ren).

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

LIMITED FIXED INDEMNITY BENEFITS

THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON:

COVERED BENEFIT FOR EACH COVERED PERSON:

Plan	Daily Benefit Amount
Daily Inpatient Surgery Anesthesia Benefit	\$XXX per day to a maximum of 2 days per Policy Period

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, 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 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 a 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 3 months prior to the Covered Person’s Effective Date of coverage.

“Prescription Drug” means drugs dispensed by a licensed pharmacist by written prescription under Federal law, and approved for general use by the Food and Drug Administration. Prescription Drugs include insulin and the needles and syringes required for its administration, if the Covered Person has a Physician’s authorization for such supplies on record with the pharmacist.

“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, 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
- 3) the next Open Enrollment (if applicable) following 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. 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 referenced date shown in the Application/Enrollment Form.

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

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.

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 30 days of lapse if it is lapsed for nonpayment of premium, if the Policyholder submits written application to the Company, the Company accepts the application and the Policyholder makes payment of all overdue premiums.

If an Insured Person's insurance ends for nonpayment of premium, insurance may be reinstated for an Insured Person and His or Her Dependents within 30 days.

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 Inpatient Surgery Anesthesia Benefit

We will pay the Daily Inpatient Anesthesia Benefit shown in the Schedule of Benefits if a Covered Person is administered anesthesia on an inpatient basis for a Medically Necessary Surgery as the result of a Covered Accident or Sickness.

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 for Mental Illness or Nervous Disorders, except as specifically provided in the Policy.
6. Treatment for Substance Abuse, except as specifically provided in the Policy.
7. 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.
8. 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.
9. 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.
10. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
11. Travel or activity outside the United States, except for a Medical Emergency.
12. Participation in any motorized race or speed contest.
13. 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.
14. Routine vision care.
15. 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.
16. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from, 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.
17. Prescription Drugs unless specifically provided for under the Policy.
18. Elective or cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body.

Pre-existing Conditions Limitation

Pre-existing Conditions will not be covered for a period of the first 6 months after the Covered Person's Effective Date of coverage.

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of claim must be given to Us within 90 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given at Our administrative office as shown on the cover page or to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

If written notice is not received within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 90-day period; and
- 2) it is further shown that notice was given as soon as possible.

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, 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.