Standard Life and Accident Insurance Company
Home Office: One Moody Plaza, Galveston, Texas, 77550
Toll-Free Telephone Number: 1-888-350-1488
(A Stock Insurance Company hereafter referred to as "Standard Life", "We", "Us", "Our" or "the Company")

GROUP LIMITED BENEFIT ACCIDENT INSURANCE POLICY

GROUP POLICY NUMBER:
EMPLOYER:
POLICY EFFECTIVE DATE:
ANNIVERSARY DATE:
STATE OF ISSUE: AZ

This Policy is a legal contract between the Employer and the Company. The Company agrees to insure eligible Employees of the Employer against loss covered by this Policy subject to its provisions, limitations, and exclusions. This Policy is non-participating.

This Policy is issued in consideration of the payment of the required premium when due and the statements set forth in the signed Policy Application, which is attached to and made part of this Policy. This Policy will take effect as of 12:01 am on the Policy effective date and continues in effect as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. The Policy Anniversary Date will be the date shown in each subsequent year.

PREMIUMS. Premiums may be changed and are due as stated the Premiums section.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If any Covered Person is eligible for Medicare, such person should review the "Guide to Health Insurance for People with Medicare" available from the Company.

The Policy is governed by the laws of the state in which this Policy was issued and delivered.

Signed for Us on the Policv Effective Date.

Secretary

President

NOTICE TO BUYER:
THIS POLICY PROVIDES LIMITED BENEFIT COVERAGE.
IT IS NOT DESIGNED TO COVER ALL MEDICAL EXPENSES AND IT IS NOT A MAJOR MEDICAL OR COMPREHENSIVE HEALTHCARE POLICY.
PLEASE READ CAREFULLY!

THE INSURANCE POLICY IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE.

TABLE OF CONTENTS

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DEFINITIONS - GENERAL

Accident or Accidental means an act or event which is unforeseen, unexpected and unanticipated, definite as to time and place, which:
1. Causes Injury to one or more Covered Persons; and
2. Occurs while the insurance is in force for the Covered Person.

Actively At Work or Active Service means an Employee who is present for at least 20 hours per week at his/her usual place of employment for the Employer or at another location as assigned or directed by the Employer, and is mentally and physically capable of performing the regular duties of the job for which he or she is employed.

On any day that is not an Employee's regularly scheduled work day (vacation, personal days, and weekends/holidays) the Employee will be considered Actively at Work on such day provided he or she is not absent due to any type of leave and was Actively at Work on his/her last regularly scheduled work day.

An Employee who usually performs the regular duties of his/her job at their home is considered Actively at Work if they meet all the above requirements and could work at the Employer's usual place of employment if required to do so.

Age means a Covered Person's Age as of his/her last birthday.

Ambulatory Surgical Center means a facility, licensed as such, that provides outpatient surgical services. It does not include a Physician's or dentist's office, a clinic, or any other such location.

Calendar Year means a period of 12 consecutive months starting on January 1 and ending on December 31 of the same year.

Certificate Effective Date is the date coverage begins for each Covered Person under the Policy. It will be different for a Covered Person added to the Policy after the original date of issue or when a change in coverage for any Covered Person occurs. Each Covered Person's Certificate Effective Date is shown in the Employee's Certificate of Coverage Schedule of Benefits.

Common Carrier means a vehicle that is duly licensed by a proper authority to transport passengers for a fee. Common Carrier vehicles are limited to airplanes, trains, buses, trolleys and boats that operate on a regularly scheduled basis between predetermined points or cities. A taxi is not a common-carrier vehicle.

Covered Person means an Employee, an Employee's spouse or Dependent children, listed as a Covered Person in the Certificate Schedule of Benefits and for whom premium has been paid.

Dependent means an Employee's family as follows:
1. The lawful Spouse*, if not legally separated or divorced;
2. Unmarried children (whether natural, adopted or stepchildren) under the limiting age of 26; or
3. Unmarried children for whom the Employee is required to provide insurance under a medical support order or an order enforceable by a court.

*The term "Spouse" as used throughout the Policy will also mean the Employee's legal Domestic Partner.

Domestic Partner means an opposite or same sex person with whom an Employee maintains a committed relationship and shares a familial relationship characterized by mutual caring and the sharing of a mutual residence and who has registered under the state law as domestic partners. Each partner must:
1. Be at least 18 years old and competent to contract;
2. Be the sole domestic partner of the other person; and
3. Not be married.

Emergency Treatment means covered services provided in a Hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of

medicine and health to believe that the individual's condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could:

1. Place the individual's health in serious jeopardy;
2. Result in serious impairment to bodily functions;
3. Result in serious dysfunction of a bodily organ or part;
4. Result in serious disfigurement; or
5. For a pregnant woman, result in serious jeopardy to the health of the fetus.

Employee means the Employee designated in the Enrollment Form who is Actively at Work and listed in an eligible class of Employees in the Employer's application. The Employee must be listed as a Covered Person in the Certificate Schedule of Benefits and appropriate premium paid in order to be covered under the Policy.

Employer means the entity or plan sponsor to whom the Group Policy is issued and shall include any affiliated entities or subsidiaries approved by the Company.

Enrollment Form means the form(s) that the Employee (and the Employee's spouse, if any) signed to apply for coverage under the Policy. It also includes any other document approved by the Company that the Employee uses to change coverage under the Policy.

Home Health Care means a program of professional, paraprofessional or skilled care for medical services provided through a Home Health Care Agency to a Covered Person in his/her home. This includes any of the following services:

1. Nursing services provided by a:
   (a) registered nurse;
   (b) licensed practical nurse;
   (c) licensed vocational nurse; or
   (d) a licensed public health nurse;
2. Physical therapy;
3. Speech therapy;
4. Respiratory therapy; or
5. Occupational therapy.

Home Health Care Agency means an agency or organization which provides Home Health Care services, and:

1. Is licensed or certified, if required by the jurisdiction in which it is located; or accredited by:
   (a) the National Home Caring Council, a Division of the Foundation for Hospice and Home Care;
   (b) the Joint Commission Accreditation of Health Care Organizations; or
   (c) the National League for Nursing;
2. Is supervised by a qualified professional such as a registered nurse or a licensed social worker;
3. Whose Employees receive appropriate specialized training; and
4. Keeps clinical records, including Physician's orders where appropriate, on all patients.

Hospice means a licensed agency, organization, or unit that provides a centrally administered and autonomous continuum of palliative and supportive care to terminally ill persons and their families. The care must be directed and coordinated by the Hospice organization and received primarily in the patient's home, or on an outpatient or short-term inpatient basis in a Hospice unit.

Hospital means an institution licensed to operate as a Hospital pursuant to the law of the state in which it is located that maintains and uses a laboratory, X-ray equipment and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises. The term "Hospital" does not include any institution or part thereof used as a Rehabilitation Unit or Rehabilitation Facility; a Hospice unit, including any bed designated as a Hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended-care facility; a Skilled Nursing Facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

Immediate Family Member means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted child or stepchild).

Injury or Injuries means Accidental bodily Injury sustained by a Covered Person in an Accident that:
1. Is the direct cause of the condition for which benefits are provided,
2. Is independent of disease or bodily infirmity or any other cause, and
3. Occurs while the insurance is in force.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Inpatient or Confined means confined overnight as a registered bed patient in a Hospital or other medical facility where at least one day's room and board is charged. Confined or Inpatient does not include a Covered Person's treatment in an Ambulatory Surgical Center, emergency room, or an observation room. The confinement must be Medically Necessary.

Intensive Care Unit (ICU) means a specifically designated unit of the Hospital that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The ICU must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the ICU on a full-time basis. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (1) Intensive Care Units, (2) Cardiac Intensive Care Units, and (3) Infant (Neonatal) Intensive Care Units.

Medically Necessary means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of an Injury. We do not consider a service or supply as Medically Necessary if:
1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. It is experimental or investigational.

The fact that a Doctor may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Outpatient means the Covered Person is not confined as Inpatient in a Hospital.

Period of Confinement means a time period of continuous confinement as an Inpatient in a Hospital. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated Injury or Sickness or the confinements are separated by 180 days.

Physician means a licensed practitioner of the healing arts acting within the scope of his/her license who is not:
1. The Covered Person; or
2. An Immediate Family Member.

Rehabilitation Facility means an institution licensed by the state where its primary purpose is to provide restorative therapy to disabled persons. Such facility must be licensed as such in the state in which it operates. "Rehabilitation Facility" does not include places for custodial care or places for confinement of drug addicts or alcoholics.

Rehabilitation Unit means a unit of a Hospital providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Skilled Nursing Facility means a lawfully operating institution or a distinct part thereof. Such facility must be engaged mainly in providing skilled nursing care and treatment for people convalescing from an Injury. It must: 1) have organized facilities for medical services; 2) provide 24 hour a day nursing services under the full-time supervision of a Physician or a registered nurse; 3) have available the services of a Physician at all times; 4) maintain daily clinical records on each patient; and 5) provide appropriate methods for dispensing and administering drugs and medicines.

A Skilled Nursing Facility will include the following facilities that are operating within the scope of their lawful licenses: 1) a rehabilitation center; 2) a transitional care unit; 3) an intermediate nursing facility; 4) an extended care facility; and 5) a nursing home.

A Skilled Nursing Facility does not mean a home or facility, or part of home or facility, that is used primarily for: 1) rest; 2) the aged; 3) alcoholics or drug addicts; 4) mental illness or disorders; 5) custodial care; or 6) educational care.

Substance Abuse means psychological or physical dependence on, or addiction to, alcohol, drugs or any other controlled substances characterized by:

1. Impairments in social and/or occupational functioning;
2. Debilitating physical condition;
3. Inability to abstain from or reduce consumption of the substance; or
4. The need for daily substance use to maintain adequate functioning.

Substance abuse includes alcohol and drugs but excludes caffeine and tobacco.

DEFINITIONS - MEDICAL TERMS

Ankle means the distal fibula, tibia, navicular, and calcaneus bones.

Bone Degeneration Disease means any disease-causing bone loss or deterioration of bone structure including but not limited to the following diagnosis: Osteoporosis, Paget's disease, osteogenesis imperfecta, bone malignancies, osteonecrosis, and metabolic bone disease.

Collarbone means the clavicle bones.

Coccyx means four fused vertebrae at the bottom of the spine.

Coma means a profound state of unconsciousness that lasts for a period of at least 96 hours and from which the Covered Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician. This does not include medically induced comas.

Dislocation means displacement or disarrangement of the normal anatomical relation of the bones in a joint in which there is loss of contact between articular surfaces.

Finger means the digits of the hand consisting of the proximal, middle and distal phalangeal bones that comprise the four fingers and the thumb.

Feet or Foot means the part of the lower extremity consisting of the calcaneus bone, cuboid bone, cuneiform bones, metatarsal bones, navicular bones, phalanges, and the bones which form the ankle. For Fracture or Dislocation purposes, the Toes are not covered.

Fracture means a break or rupture in the continuity of the bone or cartilage and includes, but is not limited to: complete fractures; compound fractures; compression fractures; depressed fractures; open fractures; simple fractures.

Green Stick Fracture means a fracture in a soft bone in which the bone bends and partially breaks.

Hairline Fracture means a break that appears as a narrow crack along the surface of the bone.

Hand means a portion of the upper Limb consisting of the wrist, palm, four fingers and thumb. For Fracture or Dislocation purposes, the Fingers are not covered.

Hip means the femoral neck.

Kneecap means the patella.

Leg means the tibia and fibula and femur/thigh.

Limb means entire arm or entire leg.

Loss of finger or toe means complete severance through or above the metacarpophalangeal joint of a Finger or metatarsophalangeal joint of a Toe.

Loss of hand or foot means permanent severance of an arm distal to the ulna and radius; or distal to the tibia and fibula of the leg respectively.

Loss of hearing means total and irrecoverable loss of the ability to perceive sound.

Loss of sight means a total, permanent and irrecoverable loss of perception to light.

Loss of speech means total and irrecoverable loss of the ability to speak.

Lower Arm means the radius and ulna.

Lower Jaw means the mandible.

Lower Leg means the tibia or fibula.

Neck means the seven cervical vertebrae.

Osteoporosis means a reduction in bone mass and loss of normal bone leading to increased susceptibility to fractures.

Paralysis/**Paralyzed** means Quadriplegia, Paraplegia, Hemiplegia or Uniplegia that is expected to last for a continuous period of 12 months or more from the earlier of the date of the Accident causing Paralysis or the date of the diagnosis. "Quadriplegia" means the complete and irreversible Paralysis of both upper and lower Limbs. "Paraplegia" means the complete and irreversible Paralysis of both lower Limbs. "Hemiplegia" means the complete and irreversible Paralysis of the upper and lower Limbs of the same side of the body. "Uniplegia" means the complete and irreversible paralysis of one Limb.

Pathological Fracture means any Fracture in an area where pre-existing disease has caused weakening of the bone.

Pelvis means the area formed by the pubic bone, ilium, and ischium.

Reduction means manipulative or surgical restoration procedures of a dislocated body part to its normal anatomical relation.

Second Degree Burn means a burn marked by pain, blistering and superficial destruction of the dermis.

Shoulder Blade means scapula.

Skull means the bones of the head collectively.

Spine/**Vertebral Column** means 7 cervical, 12 thoracic, 5 sacral, and 4 coccygeal bones.

Sternum means the breastbone located in the center of the chest. This does not include ribs.

Tailbone means the four coccygeal vertebrae.

Third Degree Burn means a burn that causes damage to subcutaneous tissue.

Toe means the digits of the foot consisting of the phalangeal bones that comprise the 5 toes.

Upper Arm means the humerus.

Upper Jaw means the maxilla.

Upper Leg means the femur/thigh.

Wrist means the proximal segment of the hand consisting of the carpal bones.

ELIGIBILITY AND EFFECTIVE DATES

The Policy Effective Date is shown on the cover page of this Policy and in the Policy Schedule.

PARTICIPATION REQUIREMENTS
All eligible Employees within a current eligible class listed in the group Application must be offered coverage under the group Policy.

The Company may require a specific participation of Employees in order to continue coverage under the Policy.

If for any reason an Employer's group participation levels fall below the percentage Participation Requirements stated in the Policy Schedule of Benefits, the Employer has a 6 month period, beginning on the premium due date that coincides with or next follows the date the event occurs, to reestablish and continue the minimum percentage Participation Requirements. If the minimum Participation Requirements are not reestablished within such time period, all insurance under the Policy for the Employer and Covered Persons will terminate.

The Company's participation requirements (if any) are shown in the Policy Schedule of Benefits.

EMPLOYEE ELIGIBILITY
An Employee is eligible to apply for coverage under this Policy if the Employee:
1. Is in Active Service;
2. Has completed the Employer's Waiting Period shown in the Employer's Application;
3. Is part of an eligible class of Employees listed in the Employer's Application; and
4. The required premium contribution has been received by the Company.

The Employer's Waiting Period is the time between the first day of employment in an eligible class of Employees and the first day that the Employee is eligible to apply for coverage under the Policy. The Employer's Waiting Period is chosen by the Employer and shown in the Policy Schedule of Benefits. The Employer's Waiting Period may differ for current Employees and new Employees. An Employee in an eligible class must enroll for coverage by submitting a completed Enrollment Form with the appropriate payroll deduction authorization within 31 days of completion of the Employer's Waiting Period.

No Employee may be eligible for insurance under the Policy as both an Employee and as a Spouse or Dependent Child at the same time. If an Employee and Spouse are both eligible to be covered as an Employee, one but not both, is eligible to cover the Dependent Children. The other Spouse may elect single coverage only.

EMPLOYEE'S EFFECTIVE DATE
An Employee's coverage will become effective on the latest of the following dates:
1. the Policy effective date;
2. the Certificate Effective Date shown in the Certificate Schedule of Benefits; or
3. the date the Employee's Enrollment Form is approved by the Company.

If the Employee is not Actively at Work on his/her Certificate Effective Date, such Certificate Effective Date will be delayed until the date the Employee returns to Active Service.

DEPENDENT ELIGIBILITY
An Employee is eligible to enroll eligible Dependents on the later of:
1. The date the Employee is eligible to be insured; or
2. The date the Employee first acquires an eligible Dependent.

The date acquired for eligible Dependents is as follows:
1. A spouse is deemed acquired on the date of marriage;
2. A natural child is deemed acquired on his/her date of birth;
3. A stepchild is deemed acquired on the date of marriage to the Employee's legal spouse;
4. An adopted child is deemed acquired on the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption; or
5. The date of a court order requiring the Employee to cover eligible Dependents.

An Employee may enroll Dependents for coverage by submitting a completed Enrollment Form within 31 days of first acquiring a Dependent along with the appropriate payroll deduction authorization in accordance with Company policies.

DEPENDENT'S EFFECTIVE DATE
An eligible Dependent's coverage under the Policy will become effective on the latest of the following dates:
1. the Policy effective date;
2. the Employee's effective date of insurance;
3. the date the Employee elects dependent coverage under the Policy; or
4. the Certificate Effective Date shown in the Certificate Schedule of Benefits; or
5. the date the Company approves the Employee's Enrollment Form for dependent coverage.

If an Employee's Dependent is unable to engage in the activities of a person in good health of like age and sex on the Certificate Effective Date, the Dependent's Certificate Effective Date will be delayed until the date such Dependent is able to engage in normal activities of a person in good health of like age and sex.

LATE ENTRANTS
If an Employee or eligible Dependent is not enrolled within 31 days after first becoming eligible, he/she will be considered a Late Entrant and may have to meet additional Evidence of Insurability requirements. Late Entrants are subject to approval by the Company.

If the Company approves the Enrollment Form, the date that insurance takes effect will be assigned by the Company and shown in the Certificate Schedule of Benefits.

EVIDENCE OF INSURABILITY REQUIREMENTS
Evidence of insurability is required for Employees and his/her eligible Dependents, at the Employee's cost, if he/she:
1. applies for coverage more than 31 days after the Employee or Dependent first become eligible;
2. voluntarily canceled insurance and reapplies;
3. is applying after coverage ended due to non-payment of premium;
4. is requesting additional coverage under the Policy; or
5. upon request by the Company.

EFFECTIVE DATE OF CHANGES
Any change in coverage will take effect on the date approved by the Company.

If the Employee is not Actively at Work on his/her last scheduled work day coincident with or preceding the date that an approved increase in his/her coverage is to take effect, such increase will be effective on the date the Employee returns to Active Service.

If an Employee's Dependent is unable to engage in the activities of a person in good health of like age and sex on the date an approved increase in his/her insurance would otherwise become effective, such increase will not be effective until the date such Dependent is able to engage in normal activities of a person in good health of like age and sex.

NEWBORN CHILDREN
The Employee's newborn child is automatically covered from the moment of birth until such child is 31 days old. Coverage for newborns shall be the same as for all other covered Employee's Dependents. If the Employee does not have other covered Dependents and wants uninterrupted coverage, the Employee will have the option to add Dependent child coverage. The Employee must notify the Company in writing within 31 days of such birth and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 31 day period.

ADOPTED CHILDREN
An adopted child is automatically covered for the first 31 days from the date of placement for the purpose of adoption by the Employee or the date of the entry of an order granting the Employee custody of the child for purposes of adoption. Coverage for such child will be the same as for all other covered Employee's Dependents. If the Employee does not have other covered Dependents and wants uninterrupted coverage, the Employee will have the option to add Dependent child coverage. The Employee must notify the Company in writing within 31 days of the date of placement or the date of the entry and pay the required additional premium (if any), in order to have coverage for the adopted child continue beyond such 31 day period.

Coverage for a child that is placed with the Employee for adoption will continue in accordance with the provisions of the Policy, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

COVERAGE OF CHILDREN

We will not deny enrollment of a child under the plan of the child's parent on the grounds that the child:

1. Was born out of wedlock;
2. Is not claimed as a dependent on the parent's federal tax return; or
3. Does not reside with the parent or in Our service area.

If the child has coverage through Us with the noncustodial parent, We will:

1. Provide any information to the custodial parent that may be necessary for the child to obtain benefits through Us;
2. Permit the custodial parent or the provider with the custodial parent's approval to submit claims for covered services without the approval of the noncustodial parent;
3. Make payments on claims that are submitted pursuant to paragraph 2 of this subsection directly to the custodial parent, the provider or the Arizona health care cost containment system.

If a court or administrative order requires a parent to provide health coverage for a child and the parent is eligible for family coverage, We will:

1. Permit the parent to enroll the child under the family coverage if the child is otherwise eligible for the coverage without regard to any enrollment season restrictions;
2. If the parent is enrolled in family coverage but fails to enroll the child, enroll the child under the family coverage on the application of the child's other parent or pursuant to Arizona law;
3. Not refuse to enroll or terminate the coverage of a child unless We receive satisfactory written evidence that one of the following applies:
   a) The court or administrative order is no longer in effect.
   b) The child will be enrolled in comparable health coverage through another insurer and the coverage will take effect not later than the effective date of the termination of coverage.
   c) The Employer has eliminated family coverage for all of its Employees.
   d) Nonpayment of premium.
4. Establish reasonable procedures for determining if a child is covered under a qualified medical support order. The procedures must:
   a) Be in writing.
   b) Provide for the notification of each person who is specified in a medical child support order as eligible to receive benefits under the plan of the procedures. The insurer shall promptly send the notice to the address included in the medical child support order on receipt by the insurer of the medical child support order.
   c) Permit an alternate recipient to designate a representative for the receipt of copies of notices that are sent to the alternate recipient pursuant to a medical child support order.

TERMINATION AND CONTINUATION

POLICY TERMINATION

The Company or the Employer can terminate or non-renew coverage under the Policy under any of the following conditions:

1. the Company or the Employer requests termination of the Policy;
2. the Employer has failed to pay premiums in accordance with the terms of the Policy or We have not received timely premium payments;
3. the Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of the Policy, subject to the provision titled Time Limit on Certain Defenses; or
4. the Employer fails to maintain the minimum Participation Requirements stated in the Policy Schedule.

If coverage is non-renewed by the Employer, the Employer is responsible for providing Employee's notice of such termination. If coverage is non-renewed by the Company, We will provide advance notice of termination in accordance with state law.

Termination of coverage will not affect a claim for a covered loss that occurred while the Insured's coverage was in force under the Policy.

COVERED PERSON'S TERMINATION

Coverage under the Policy for a Covered Person ends on the earliest of:

1. the date the Policy is terminated by the Company or the Employer;
2. the premium due date if premiums are not paid when due, subject to the Grace Period;
3. the date a Covered Person performs an act or practice that constitutes fraud;
4. the date the Employee requests, in writing, that the coverage be terminated;
5. the date the Employee ceases to be in an eligible class of Employees; or
6. the date the Dependent does not meet the definition of an eligible Dependent.

If coverage is non-renewed by the Employer, the Employer is responsible for providing Employee's notice of such termination. If coverage is non-renewed by the Company, We will provide advance notice of termination in accordance with state law.

Termination of coverage will not affect a claim for a covered loss that occurred while the coverage was in force under the Policy.

CONTINUATION OF COVERAGE FOR AN INCAPACITATED CHILD

When a Dependent child reaches the limiting age as defined in the definition of Dependent and continues to be both: (a) incapable of self-sustaining employment by reason of mental incapacity or physical handicap; and (b) remains dependent upon the Employee for support and maintenance, coverage for such child will continue while the coverage is in force and so long as such incapacity continues and the applicable premium is paid.

Satisfactory proof must be submitted to Us by the Employee within 31 days of such termination date. During the next two years we may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year. The premium for such child's continued coverage will be the same as for an adult of like age and sex.

CONTINUATION - UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if an Employee's insurance would otherwise end because he/she enters into active military duty or inactive military duty for training, the Employee may elect to continue insurance (including Dependent's insurance) in accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The Employer is responsible for meeting all of the obligations under USERRA, including notifying all Employees and Dependents of their rights under USERRA.

CONTINUATION - FAMILY AND MEDICAL LEAVE ACT (FMLA)

(Applies to Employers with 50 or more Employees)

Federal law requires that if an Employee's insurance would otherwise end because of family and medical reasons, he/she may be entitled to continue insurance (including Dependent's insurance) in accordance with the Family and Medical Leave Act of 1993 (FMLA). The Employer is responsible for meeting all of the obligations under FMLA, including notifying all Employees and Dependents of their rights under FMLA.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT ("COBRA")

Applies to Employers with 20 or more Employees

Applicability: Federal law requires that Employers of 20 or more Employees for at least 50% of the preceding year, offer a temporary extension of health coverage to Qualified Beneficiaries when coverage would otherwise end because of the occurrence of one or more of Qualifying Events listed below. Under COBRA, a Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not (1) already covered under the Policy by reason of another individual's election of COBRA, or (2) entitled to Medicare benefits under Title XVIII of the Social Security Act.

Qualifying Event: For purposes of coverage under COBRA, the term "Qualifying Event" means, with respect to any Covered Person, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage for a Qualified Beneficiary.

Qualifying Events	Duration of Continued Coverage
• death of an Insured	36 months
• termination of employment for any reason except gross misconduct, or the reduction in hours that would result in loss of coverage	18 months*
• divorce or legal separation	36 months
• Insured becomes eligible for Medicare	Dependents & spouse allowed 36 months
• Insured Dependent no longer meets Insured Dependent eligibility requirements	36 months

*Coverage may be continued an additional 11 months if the Qualified Beneficiary:
- is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
- notifies the plan administrator within 60 days from determination (but before the 18 month continuation period ends).

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months for all Qualifying Events.

Notice and Election: Covered Persons are responsible for notifying the Employer in the case of a divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The Employer must notify the plan administrator of the Qualifying Event. The Employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of:

- the date on which coverage terminates under the Policy by reason of a Qualifying Event, or
- the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

Premium Payment: The Qualified Beneficiary must pay to the Employer or the COBRA Administrator the required monthly premium. Any Grace Period applying to the Employer will also apply to the Qualified Beneficiary, except the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of election.

COBRA Termination occurs at the earlier of:

- the premium for continued coverage is not paid within 31 days from being due;
- the Qualified Beneficiary becomes covered under another group health plan, if that plan does not contain any exclusion or limitation on any Pre existing Conditions of the Qualified Beneficiary;
- the Qualified Beneficiary becomes eligible for Medicare;
- the Qualified Beneficiary, who is divorced from an Insured Employee, remarries and is covered under the new spouse's medical plan; or
- the Employer no longer provides medical benefits of any kind.

BENEFITS AND COVERAGES

Benefits described below are payable as stated in the Employee's Certificate Schedule of Benefits when a Covered Person receives Medically Necessary treatment while coverage is in force, subject to any applicable terms, exclusions or limitations.

HOSPITAL BENEFITS

Hospital Admission Benefit:

For the day that a Covered Person is admitted as an Inpatient in a Hospital for treatment of an Injury, the Company will pay the Hospital Admission Benefit shown in the Certificate Schedule of Benefits.

The Hospital Admission Benefit is payable once during each Period of Confinement.

Hospital Confinement Benefit:

When a Covered Person is Confined to a Hospital for treatment of an Injury in a room for which the Intensive Care Unit Benefit is not payable, the Company will pay the Daily Hospital Confinement Benefit shown in the Certificate Schedule of Benefits for each day that a Covered Person is Confined.

The Daily Hospital Confinement Benefit is payable subject to the Maximum Hospital Confinement Benefit Period shown in the Certificate Schedule of Benefits for each Period of Confinement.

This benefit is not payable if the Covered Person is receiving Intensive Care Unit Benefits under the Policy.

This benefit is not payable if the Covered Person is Confined for the treatment of a Mental or Nervous Disorder or Substance Abuse.

No benefits are payable for treatment received in an emergency room, any Outpatient setting, skilled nursing facility, rehabilitation facility, rehabilitation Unit, hospice or any other facility other than a Hospital.

Intensive Care Unit Benefit:

When a Covered Person is confined in and charged for an Intensive Care Unit for treatment of an Injury, the Company will pay the Daily Intensive Care Unit Benefit shown in the Certificate Schedule of Benefits for each day a Covered Person is confined in and charged for an Intensive Care Unit.

This benefit is paid in lieu of and not in addition to the Daily Hospital Confinement Benefit under the Policy.

The Daily Intensive Care Unit Benefit is payable subject to the Maximum Intensive Care Unit Benefit Period shown in the Certificate Schedule of Benefits for each Period of Confinement.

AMBULATORY SURGICAL CENTER BENEFIT

For each day that a Covered Person receives surgery for the treatment of an Injury in an Ambulatory Surgical Center, We will pay the Ambulatory Surgical Center Benefit listed in the Certificate Schedule of Benefits.

AMBULANCE BENEFIT

For each day that a Covered Person requires ground or air ambulance transportation to a Hospital or other medical facility for Emergency Treatment of an Injury, the Company will pay the Ground Ambulance Benefit or the Air Ambulance Benefit, subject to the Maximum Number of Days shown in the Certificate Schedule of Benefits.

A licensed professional ambulance company must provide the ambulance service.

EMERGENCY ROOM BENEFIT

For each day that a Covered Person receives Emergency Treatment in the emergency room of a Hospital or freestanding emergency medical care facility due to an Injury resulting from a covered Accident, the Company will pay the Emergency Room Benefit, subject to the Maximum Number of Days shown in the Certificate Schedule of Benefits. To receive benefits due to an Injury, the Covered Person must seek Emergency Room Treatment within 72 hours of the covered Accident.

CONTINUOUS CARE BENEFIT

If a Covered Person is Confined to a Hospital for treatment of an Injury and upon discharge requires Continuous Care, We will pay the Daily Benefit for each day subject to the Maximum Continuous Care Benefit Period shown in the Certificate Schedule of Benefits.

Continuous Care means care received in a Skilled Nursing Facility, Rehabilitation Facility, Rehabilitation Unit or Home Health Care or Hospice care in connection with the condition for which he or she was hospitalized.

The following conditions must be met before Continuous Care benefits are payable:
1. Continuous Care must begin within 7 days following discharge from Inpatient care in a Hospital;
2. Continuous Care must be for the same Injury for which the Covered Person was hospitalized;
3. The Continuous Care must be prescribed by a Physician and must be Medically Necessary for the care and treatment of the Covered Person's condition;
4. Home Health Care services must be performed by a Home Health Care Agency. Home Health Care services cannot be performed by a person who lives with the Covered Person or by the Covered Person's Immediate Family Member;
5. Hospice care services require: (a) a written statement from the attending Physician that the Covered Person has a life expectancy of six (6) months or less, and (b) a written statement from the Hospice certifying the days that services were provided.

The Daily Benefit is payable once per day regardless of how many Continuous Care services are provided on that day.

No benefits are payable if the Covered Person is Hospital Confined.

SURGICAL AND ANESTHESIA BENEFITS

Surgery Benefit:
For each day that a Covered Person undergoes a surgical procedure performed by a Physician in the operating room of a Hospital or an Ambulatory Surgical Center for treatment of an Injury, the Company will pay the Surgery Benefit shown in the Certificate Schedule of Benefits.

Procedures that are performed or can otherwise be performed in another setting are not covered under this benefit. We will pay only one daily benefit regardless of the number of surgical procedures occurring in one day, even if caused by more than one Injury.

Anesthesia Benefit:
For each day that a Covered Person is administered anesthesia during a surgical procedure covered under the Policy, the Company will pay the Anesthesia Benefit shown in the Certificate Schedule of Benefits.

Services must be administered by a licensed anesthesiologist or certified registered nurse anesthetist (CRNA).

OUTPATIENT PHYSICIAN'S OFFICE VISIT BENEFIT

For each day that a Covered Person visits a Physician's office, clinic or urgent care facility for treatment of an Injury, the Company will pay the Physician's Office Visit Benefit subject to the Maximum Number of Visit Days shown in the Certificate Schedule of Benefits.

No benefits are payable under this provision for Mental or Nervous Disorders or Substance Abuse.

OUTPATIENT DIAGNOSTIC, X-RAY LAB AND ADVANCED STUDIES BENEFIT

For each day that a Covered Person receives Outpatient Diagnostic X-ray, Lab and Advanced Studies Tests for the treatment of an Injury, as ordered or performed by a Physician, We will pay the Benefit Amount shown in the Certificate Schedule of Benefits, subject to the maximum number of test days listed in the Certificate Schedule of Benefits.

"Advanced studies Tests" consist of the following: Magnetic Resonance Imaging **(MRI)**; Magnetic Resonance Angiography **(MRA)**; Computed Axial Tomography **(CAT Scans)**; Positron Emission Tomography **(PET Scans)**; and Computed Tomography **(CT Scans)**.

WELLNESS AND PREVENTIVE CARE BENEFIT

For each day that a Covered Person receives Wellness and Preventive Care under the supervision of a Physician, We will pay the Benefit Amount shown in the Certificate Schedule of Benefits.

Wellness and Preventive Care (care for reasons other than to diagnose or treat a suspected or identified Injury) means an office visit and related procedures for the following: 1) a routine history and physical examination; 2) cervical cytological screening (pap test), colorectal cancer screening, prostate cancer screening, routine mammography screening, or bone density screening; or 3) childhood immunizations as recommended by the Department of Health and Human Services and Centers for Disease Control and Prevention.

Only one daily benefit will be paid for the combined services listed under Wellness and Preventive Care. The Benefit Amount is payable subject to the Maximum Number of Days shown in the Certificate Schedule of Benefits.

ACCIDENTAL DEATH BENEFIT

If a Covered Person suffers an Injury that results in the Covered Person's Death within 90 days of the date of the Accident that caused the Injury, the Company will pay the Accidental Death Benefit listed in the Certificate Schedule of Benefits when the Company receives proof that the Covered Person's death:

1. Resulted directly and independently of all other causes from the Accident;
2. Occurs while the coverage is in force.

This benefit is not payable if the Common Carrier Benefit is eligible to be paid.

COMMON CARRIER BENEFIT

If a Covered Person suffers an Injury that results in death and the Accident causing death occurs while riding in or on a Common Carrier, the Company will pay the Common Carrier Benefit listed in the Certificate Schedule of Benefits. This benefit is paid in lieu of the Accidental Death Benefit.

This benefit will also apply if the Accident occurs while entering or exiting, getting in or out of, or on or off of, the Common Carrier. A Taxi is not a Common Carrier.

ACCIDENTAL DISMEMBERMENT BENEFITS

If a Covered Person suffers an Injury that results in a Dismemberment specified in the Certificate Schedule of Benefits within 90 days of the date of the Accident that caused the Injury, the Company will pay the Benefit Amount listed in the Certificate Schedule of Benefits.

If a Covered Person suffers one or more losses from the same Accident for which amounts are payable under more than one benefit category, the amount payable will be limited to only one of the covered losses, the largest to which the Covered Person is entitled.

PARALYSIS BENEFIT

If a Covered Person is Paralyzed due to an Injury, the Company will pay the applicable Benefit Amount shown in the Certificate Schedule of Benefits for that type of Paralysis.

If the Covered Person suffers more than one type of Paralysis as a result of the same Accident, only one amount, the largest, will be paid.

PROSTHESIS BENEFIT

If a Covered Person suffers an Injury that requires initial placement of an external Prosthesis, the Company will pay the Prosthesis Benefit shown in the Certificate Schedule of Benefits.

Prosthesis means a device which replaces all or part of an external body part or replaces all or part of the function of a permanently inoperative or malfunctioning external body part. Prosthesis does not mean a device or appliance surgically inserted into the body and does not include:

- dental aids, including false teeth,
- eyeglasses,
- cosmetic prosthesis such as hair wigs,
- other types of prosthesis devices that are permanently implanted such as artificial hip or tooth,
- any experimental prosthesis,
- any auditory prosthesis (a device that substitute for or enhances ability to hear).

No benefits are payable for the replacement of external prosthetic devices.

COMA BENEFIT

If a Covered Person suffers an Injury that results in a Coma, the Company will pay the Coma Benefit shown in the Certificate Schedule of Benefits.

This benefit is payable once during each Period of Confinement.

No benefits are payable for medically induced comas.

FRACTURE BENEFIT

If a Covered Person suffers an Injury that results in the diagnosis and treatment by a Physician for a Fracture specified in the Certificate Schedule of Benefits within 30 days of the date of the Accident that caused the Injury, the Company will pay the Benefit Amount listed in the Certificate Schedule of Benefits.

In the event of multiple Fractures during the same Accident, only one covered Fracture Benefit, the largest to which the Covered Person would be eligible to receive, will be payable.

The Fracture must require Reduction of the bone under anesthesia to be covered under this provision.

No benefits are payable for:

1. Pathological Fracture;
2. Hairline Fracture or Green Stick Fracture;
3. Fractures to the Toes or Fingers; or
4. Fractures when Bone Degeneration Disease was diagnosed prior to the Covered Person's Certificate Effective Date, regardless if the Bone Degeneration Disease contributed to the Injury or not.

If a Covered Person is diagnosed as having Bone Degeneration Disease after their Certificate Effective Date and suffers a Fracture, the first Fracture will be covered under the regular terms of the Policy. However, after the first, all further Fractures of any area payable under the Policy will be reduced by 50%. This limitation applies regardless if the Bone Degeneration Disease contributed to the Injury or not.

DISLOCATION BENEFIT

If a Covered Person suffers an Injury that results in diagnosis and treatment by a Physician for a Dislocation specified in the Certificate Schedule of Benefits within 30 days of the date of the Accident that caused the Injury, the Company will pay the Benefit Amount listed in the Certificate Schedule of Benefits.

The Dislocation must require Reduction of the joint or bone to a normal position under anesthesia to be covered under this provision.

In the event of multiple Dislocations during the same Accident, only one covered Dislocation Benefit, the largest to which the Covered Person would be eligible to receive, will be payable.

No benefits are payable for:
1. Dislocations of the Toes or Fingers;
2. Subsequent Dislocations of the hip, shoulder or knees after the first Dislocation; or
3. Dislocations when Bone Degeneration Disease was diagnosed prior to the Covered Person's Certificate Effective Date, regardless if the Bone Degeneration Disease contributed to the Injury or not.

If a Covered Person is diagnosed as having Bone Degeneration Disease after their Certificate Effective Date and suffers a Dislocation, the first Dislocation will be covered under the regular terms of the Policy. However, after the first, all further Dislocations of any area covered under the Policy will be reduced by 50%. This limitation applies regardless if the Bone Degeneration Disease contributed to the Injury or not.

BURN BENEFIT

If a Covered Person suffers an Injury that results in diagnosis and treatment by a Physician for a Second Degree Burn or Third Degree Burn listed in the Certificate Schedule of Benefits, the Company will pay the Benefit Amount listed in the Certificate Schedule of Benefits.

The Company has a right, at Our own expense, to have the Physician's determination verified by a Physician of the Company's choice.

In the event of multiple Burns during the same Accident, only one covered Burn Benefit, the largest to which the Covered Person would be eligible to receive, will be payable.

TRANSPORTATION BENEFIT

For each day that a Covered Person requires transportation by private automobile, aircraft, railroad, or bus between his/her residence to a Hospital for treatment of an Injury, the Company will pay the Transportation Benefit subject to the Maximum Number of Days shown in the Certificate Schedule of Benefits.

This benefit will be paid for the Covered Person for whom the treatment is prescribed by a Physician and, except for transportation by private automobile, one adult Immediate Family Member of the Covered Person.

No benefits are payable for transportation to any Hospital located within a 100 mile radius of the residence of the Covered Person or for transportation by ambulance.

LODGING BENEFIT

For each day that a Covered Person requires treatment of an Injury at a Hospital located more than 100 miles from his/her residence that necessitates lodging at a motel, hotel or other Company approved facility for the Covered Person or any one of his/her adult Immediate Family Members, the Company will pay the Lodging Benefit shown in the Certificate Schedule of Benefits.

We will pay benefits subject to the Maximum Number of Days shown in the Certificate Schedule of Benefits.

This benefit does not apply to private residences. No benefits are payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS:

No coverage shall be provided and no benefits will be paid for any loss resulting in whole or in part from, or contributed to, or as a natural and probable consequence of any of the following:

1. Suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or any act of auto-eroticism, while sane or insane;

2. Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Covered Person is:
   a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
   b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   c. riding as a passenger in an aircraft owned, leased or operated by the Covered Person's employer;

3. Declared or undeclared war, or any act of declared or undeclared war;

4. Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Covered Person is not covered due to his/her active duty status will be refunded. Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);

5. The Covered Person's being intoxicated (defined as blood alcohol concentration equal to or in excess of .08 gms/dl blood alcohol). This applies whether or not the Covered Person is charged with any violation in connection with a loss and there is no need to prove a loss was caused, contributed to, or resulted from the excessive blood alcohol concentration;

6. The Covered Person's: a) voluntary use of illegal drugs; b) the intentional taking of over the counter medication not in accordance with recommended dosage and warning instructions; and c) intentional misuse of prescription drugs;

7. The Covered Person's commission of or attempt to commit a felony;

8. The Covered Person being engaged in an illegal occupation;

9. Services and supplies which are not Medically Necessary to treat a covered loss (other than as stated in the Wellness and Preventive Care Benefit);

10. Services and supplies which are received without charge or legal obligation to pay or would not normally be paid in the absence of insurance;

11. Services and supplies which are received outside of the United States of America, its possessions and territories;

12. Dental care or treatment unless due to an Injury to a sound and natural tooth;

13. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace, or remove breast implants; however, this Exception does not apply when surgery is required:
    a) To repair a birth defect of a child born or adopted by the Employee and continuously covered under the Policy from birth; or
    b) For reconstructive surgery following a covered mastectomy;

14. Any covered loss that is covered under any state or federal Workers' Compensation, Employer's Liability law or similar law;

15. Any Mental or Nervous Disorder or Substance Abuse unless such coverage is expressly provided herein;

16. Any procedure for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices;

17. Pregnancy or maternity. Complications of Pregnancy are not excluded;

18. Participating in hazardous occupations or other activity including participating, instructing, demonstrating, guiding or accompany others in the following: professional or semi-professional sports, extreme sports, organized body contact sports, parachute jumping, hot-air ballooning, hang-gliding, base jumping, mountain climbing, bungee jumping, scuba diving, sail gliding, parasailing, parakiting, rock or mountain climbing, cave exploration, parkour, racing including stunt show or speed test of any motorized or non-motorized vehicle, rodeo activities, or similar hazardous activities. Also excluded is Injury received while practicing, exercising, undergoing conditional or physical preparation for such activity;

19. A custodial institution, domiciliary care or rest cures;

20. Weight reduction or treatment of obesity, including exogenous, endogenous or morbid obesity; or

21. Diagnosis or treatment (including surgery) of sexual dysfunctional disorders or inadequacy, or transsexual surgery.

PREMIUMS

PREMIUM DUE DATE The initial premium is for the term shown on the Certificate Schedule of Benefits. The renewal premium for later periods of coverage is due on the first day of the next term. This coverage will end (lapse) if the renewal premium in effect is not paid before the end of the Grace Period.

If payroll deduction facilities are available to the Employee, the premium will be deducted from the Employee's pay and remitted to Us by the Employer.

PREMIUM ADJUSTMENT
The Company may change the premium rates from time to time with at least sixty (60) days advance written notice to the Employer. No change in premium will take effect before the first Policy Anniversary unless the terms of the coverage change.

The Company reserves the right to change rates at any time if any of the following events take place:
1. the terms of the Policy change;
2. the Participation Requirements stated in the Policy Schedule of Benefits are not met; or
3. any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

The Company will not extend retroactive coverage, or termination, to Employees or Dependents due to clerical errors by the Employer, for a time period greater than sixty (60) days.

GRACE PERIOD
A Grace Period may apply to any premium payments made in any mode other than a single premium. Premium payments after the initial premium payment may be paid within the Grace Period. The Grace Period will last for 31 days after the due date of the premium payment. During the Grace Period, the coverage will remain in force. However, the Company is not obligated to pay any claims incurred during the Grace Period until the premium due is received. If premium payments are not made by the end of the Grace Period, the coverage will immediately cease to be in force.

No Grace Period will be provided if the Company receives notice to terminate the Covered Person's coverage prior to a premium due date.

UNPAID PREMIUM
Any due and unpaid premium may be deducted from any benefits then payable.

PREMIUM REFUND AT DEATH
If a Covered Person's coverage terminates due to death, the Company will refund the pro rata unearned portion of any premium paid for such Covered Person.

PREMIUM CHANGE DUE TO TERMINATION OF COVERAGE
Future premiums for coverage will be adjusted, if necessary, when coverage for a Covered Person ends. If the Company accepts a premium for a Covered Person whose coverage should have ended, such premium will be refunded.

MISSTATEMENT OF AGE
If premiums for the Covered Person are based on age and the Covered Person's age has been misstated, there will be an adjustment of premiums based on his/her true age. If the benefits for which the Covered Person is eligible are based on age and the Covered Person's age has been misstated, there will be an adjustment of said benefit based on his/her true age. The Company may require satisfactory proof of age before paying any claim.

REINSTATEMENT
The Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Employer satisfactory to Us and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

CLAIM PROVISIONS

NOTICE OF CLAIM
The Employee must give the Company written notice of a claim. It should be given within 60 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by the Employee or on behalf of the Employee to Us at our Home Office, or to any authorized agent of the Company, with information sufficient to identify the Covered Person, will be deemed notice to the Company.

CLAIM FORMS
The Company will send the Employee a claim form when a notice of claim is received. If the form is not furnished within 15 days from the time the Employee gives notice, the Employee may fulfill the proof of loss requirements by sending written proof covering the occurrence, the character and the extent of the loss for which claim is made within the time set in Proof of Loss.

PROOF OF LOSS
The Employee must give the Company written proof of loss within 90 days after such loss. If it is not reasonably possible to do so, the Company will not reduce or deny the Employee's claim for being late if proof is given as soon as reasonably possible. It must, however, be given within 15 months from the date of loss, unless the Employee is not legally capable.

TIME OF PAYMENT OF CLAIMS
Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS
Benefits for loss of life will be payable in accordance with the Beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such benefits will be payable to the estate of the Employee. Any other accrued indemnities unpaid at the Employee's death may, at Our option, be paid either to such Beneficiary or to such estate. All other indemnities will be payable to the Employee.

If any benefit is payable to the estate of the Employee, or to an Employee or Beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Employee or Beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

ASSIGNMENT
An Employee may assign all of his/her rights, privileges and benefits under the Policy without the consent of his/her designated Beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

CHANGE OF BENEFICIARY
The right to change a Beneficiary is reserved for the Employee, and the consent of the Beneficiary or beneficiaries is not required for the surrender or assignment of the benefits, for any change of Beneficiary or beneficiaries, or for any other changes in the coverage.

PHYSICAL EXAMINATIONS AND AUTOPSY
The Company may have a Covered Person examined at its own expense as often as it may reasonably require while their claim is pending under the Policy and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS
No action at law or in equity shall be brought to recover under the Policy for at least 60 days after the Employee has given the Company written proof of loss in accordance with the requirements of the Policy. The Employee cannot start such action more than 3 years after the date proof of loss is required to be furnished.

NO ASSUMPTION OF LIABILITY

Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no covered loss occurred; or
2. We determine that Our payment was erroneous or inappropriate.

RIGHT OF RECOVERY

When an overpayment has been made by Us, We will have the right to: a) recover that overpayment from the person to whom or on whose behalf it was made; or b) offset the amount of that overpayment from a future claim payment.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES
The Policy, the Application(s), the Riders (if any), and any attached papers make up the entire contract between the Employer and the Company.

In the absence of fraud, all statements made by the Employee will be considered representations and not warranties. No written statement made by the Employee will be used in any contest unless a copy of the statement is furnished to the Employee or his/her Beneficiary or personal representative.

No change in the Policy will be valid until approved by an executive officer of the Company. The approval must be attached to the Policy. No agent may change the Policy or waive any of its provisions.

The Company may amend or change the Policy by written agreement with the Employer. We may amend or change the Certificate at any time, without the consent of the Employer, the Employee, any Covered Person or beneficiary, if required by law. Any amendment will be without prejudice to any charge incurred prior to the effective date of the change.

TIME LIMIT ON CERTAIN DEFENSES
After 2 years from the Certificate Effective Date, no misstatements, except fraudulent misstatements, made by the Employee in the Enrollment Form for coverage will be used to void the coverage after the expiration of the two-year period.

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 Employer is located is hereby amended to conform to the minimum requirements of those statutes.

WORKERS' COMPENSATION
This coverage is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by Workers' Compensation insurance.

CERTIFICATES OF COVERAGE
A Certificate of Coverage will be delivered to each Employee, or to the Employer for delivery to the Employee. The Certificate of Coverage will describe insurance coverage to which that person is entitled, to whom the insurance benefits are payable and a statement of the Employee's dependent's coverage. The benefits and coverage terms described in the Certificate of Coverage are controlled by the provisions of the Policy and are subject to any changes in the Policy.

POLICY CHANGES
We may agree with the Employer to modify a plan of benefits without the Employee's or Dependent's consent.

EXAMINATION OF THE POLICY
This Policy will be available for inspection at the Employer's office during regular business hours.

EXAMINATION OF RECORDS
We will be permitted to examine all of the Employer's records relating to this Policy. Examination may occur at any reasonable time while the Group Policy is in force; or it may occur:
1. at any time for two years after the expiration of this Group Policy; or, if later,
2. upon the final adjustment and settlement of all Group Policy claims.

The Employer is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Employer will not be considered Our actions.

ERISA
The Employer has established and maintains an employee welfare benefit plan as defined in the Employee Retirement Security Act of 1974, as amended, to provide the benefits described in the Policy to its Employees and their Dependents. These benefits are insured by Us under the Policy, which the Employer endorses. The Employer is the Plan Administrator, Plan Sponsor, named fiduciary, and, if applicable, Plan Trustee, for the Plan. For more information about the plan, consult the Policy. ERISA does not apply to certain plans, such as government plans and church plans.