

SERFF Tracking Number: FRCS-127372343 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 49610
Company Tracking Number: 5582
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Association Accident Only Filing
Project Name/Number: Lincoln/62/62

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Association Accident Only Filing SERFF Tr Num: FRCS-127372343 State: Arkansas

TOI: H02G Group Health - Accident Only SERFF Status: Closed-Approved- State Tr Num: 49610
Closed

Sub-TOI: H02G.000 Health - Accident Only Co Tr Num: 5582 State Status: Approved-Closed

Filing Type: Form

Author: Kevin Wiggs

Reviewer(s): Rosalind Minor

Date Submitted: 08/22/2011

Disposition Date: 08/24/2011

Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Lincoln/62

Status of Filing in Domicile: Not Filed

Project Number: 62

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Not yet submitted
in domicile state (IN).

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Association

Overall Rate Impact:

Filing Status Changed: 08/24/2011

State Status Changed: 08/24/2011

Deemer Date:

Created By: Kevin Wiggs

Submitted By: Kevin Wiggs

Corresponding Filing Tracking Number:

Filing Description:

OUT OF STATE GROUP FILING

We have been retained by The Lincoln National Life Insurance Company to file the captioned form for approval in your state.

Our fee of \$50 has been sent by EFT on this same date.

The captioned form is a new form and will not replace any previously filed forms with your Department. The form will be

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used in conjunction with the company's Group Accident Certificate Form GL42-1-FP AR, which was previously approved in your state. Please refer to SERFF Filing # JEPT-126576276, approved on 4/8/2010.

The referenced group certificate form was previously approved primarily for use with Employer groups. The company is now asking that the approval be extended for sales to members of Association groups. Possible association groups may include, but will not be limited to the following associations: Catholic Cemetery Conference, which is situated in Illinois; The Recreational and Welfare Association, Inc. of the National Institute of Health, which is situated in the District of Columbia; and the American Benefits Association, which is situated in New Jersey. Coverage will be made available to members and employees of employer members of these Associations.

Copies of the Specimen Situs State Certificates and the Appendix of Variability for your state are attached under the Supporting Documentation tab.

The Company also wishes to extend the approval of the previously approved Accident Only Disability Rider, Accident-Sickness Disability Rider, Health Assessment Rider, Sickness Hospital Confinement Rider, and Group Application for use with the captioned forms. These forms were previously approved as part of the SERFF Filing # referenced above for the certificate form.

The Company also wishes to extend the approval of Certificate Amendment form GL42-R-ACC.PPACA AR approved under SERFF # JEPT-126935262 on 12/9/2010. This form amends the definition of Dependent and is used upon request of the Group Policyholder.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

Company and Contact

Filing Contact Information

Kevin Wiggs, Compliance Specialist kevin.wiggs@firstconsulting.com
1020 Central 800-927-2730 [Phone] 2736 [Ext]
Suite 201 816-391-2755 [FAX]
Kansas City, MO 64105

Filing Company Information

(This filing was made by a third party - FC01)

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana
350 Church Street Group Code: 20 Company Type:

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MPM1 Group Name: State ID Number:
Hartford, CT 06103-1106 FEIN Number: 35-0472300
(860) 466-2908 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: AR fee of \$50 per form.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	\$50.00	08/22/2011	50843333

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/24/2011	08/24/2011

SERFF Tracking Number: *FRCS-127372343* *State:* *Arkansas*
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Disposition

Disposition Date: 08/24/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Form Schedule

Lead Form Number: GL42-AMEND.ASSN1 AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 08/24/2011	GL42- AMEND.AS SN1 AR	Certificate	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Initial		57.000	GL42- AMEND ASSN1 AR.pdf

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: [000000000000]
ISSUED TO: [ABC Association]
FOR CERTIFICATES DELIVERED IN: Arkansas
[FOR: Plan 1/Class 1/Participating Organization XYZ]

A. The Certificate Face Page is amended by adding the following disclosure:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions, then you may contact the insurance company at the above address or phone them at [1-800-423-2765]. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at [Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas 72201] or phone them at [1-800-852-5494 or 1-501-371-2640]. Please have your policy number available.

B. The definition of Terrorism under DEFINITIONS is deleted in its entirety.

C. The Dependent section under ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT ACCIDENT INSURANCE is amended to read:

DEPENDENT means your:

- (1) legal spouse, who is not legally separated from you;
- (2) unmarried child less than 19 years of age; [or]
- [(3) unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or]
- (4) unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability; and
 - (b) chiefly dependent upon you for support and maintenance.

The child must be covered by the [Group Policyholder's/Participating Organization's] Accident plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company **upon request. The premium will continue at the Dependent rate.**

[Dependent will also include a child that you are required to provide insurance under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).]

**CERTIFICATE AMENDMENT
(Continued)**

"Child" includes:

- (1) your natural child or legally adopted child;
- (2) a child placed **under your charge, care or control for whom you have filed a petition to adopt, from:**
 - (a) **the moment of birth, if the petition of adoption and application for coverage is filed within 60 days after the birth of the minor; or**
 - (b) **the date of the filing of a petition for adoption, if you apply for coverage within 60 days after the filing of the petition for adoption;**
- (3) a child for whom you are required by court order to provide Accident insurance;
- (4) a stepchild **[or grandchild]** who resides in your household; and who is chiefly dependent on you for support; and
- (5) a foster child:
 - (a) who resides in your household;
 - (b) who is chiefly dependent on you for support; and
 - (c) for whom you have assumed full parental responsibility and control.

D. The Exception for Newborn under ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT ACCIDENT INSURANCE is amended to read:

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically insured for the first **90 days** following birth. If you elect not to enroll the newborn child and pay any additional premium within **90 days** following birth, the newborn child's insurance will terminate.

E. The war exclusion under LIMITATIONS AND EXCLUSIONS is amended by deleting the reference to terrorism.

This Amendment applies only to Certificates delivered in the State of **Arkansas. This Amendment takes effect on **[Month, Day Year]**, or on your effective date of coverage under the Policy; whichever is later. In all other respects, the Certificate remains the same.**

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AUTH_2011.pdf AR Assn Readability Cert.pdf AR CoC.pdf	Approved-Closed	08/24/2011
Bypassed - Item: Application Bypass Reason: Not applicable with this amendment filing. Comments:	Approved-Closed	08/24/2011
Satisfied - Item: Appendix of Variability Comments: Attachment: AR Assn Appendix of Variability.pdf	Approved-Closed	08/24/2011
Satisfied - Item: Three situs state certificates Comments: Attachments: DC The Recreational and Welfare Association Inc of NIH certificate.pdf IL Catholic Cemeteries Conference Accident Only Certificate.pdf NJ American Benefits Association certificate.pdf	Approved-Closed	08/24/2011

August 19, 2011

To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

The Lincoln National Life Insurance Company

By:



Title: Vice President, Product Compliance & State
Filing

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

READABILITY CERTIFICATION

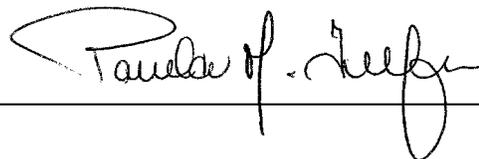
This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

FORM NO.

GL42-AMEND.ASSN1 **AR**

FLESCH SCORE

57.0

A handwritten signature in black ink, appearing to read "Pamela M. Telfer", is written over a horizontal line.

(An Officer of the Company)
Pamela M. Telfer
Vice President, Product Compliance & State
Filing

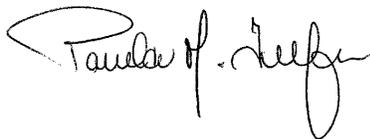
STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Company Name: The Lincoln National Life Insurance Company

Form Title(s): Certificate Amendment

Form Number(s): GL42-AMEND.ASSN1 AR

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Pam Telfer
Vice President, Product Compliance & State Filing

August 19, 2011
Date

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

APPENDIX OF VARIABILITY

For Forms:

GL42-AMEND.ASSN1 AR

The above forms are for use with Group Certificate Series GL42.

Statement of Variable Material. Variable material is denoted in the forms by underlining or bracketing. The following variability is requested.

The Lincoln National Life Insurance Company

AMENDMENTS. On GL42-AMEND.ASSN1 AR, we request variable filing of:

- A. The group policy number, group policyholder name, plan/class number (if applicable), Participating Organization (if applicable), amendment effective date and signature block.
- B. The contact information for the Company and for the Department in the **IMPORTANT INFORMATION REGARDING YOUR INSURANCE**.
- C. Item B. may be removed in its entirety in the event the policy has no limitation for terrorism; if removed, the remaining items will be numbered accordingly.
- D. The entire bracketed Dependent sections so that they may be omitted if dependents are not to be covered; if omitted, the remaining items will be numbered accordingly.

In the **DEPENDENT** section, the following variability applies.

- 1. In Item (2) of the first paragraph:
 - a. the underlined ages in item (2) are filed as variable so that they may be increased but not decreased (19 – 30); and
 - b. "regardless of student status" may be included at the end of item (2) if dependent coverage is extended to cover dependent children regardless of student status to match the group's medical plan or administrative guidelines.
 - 2. Item (3) of the first paragraph:
 - a. may be omitted if the dependent coverage is extended to cover dependent children regardless of student status to match the group's medical plan or administrative guidelines; or
 - b. the underlined ages may be increased (19-30).
 - 3. In item (4) of the first paragraph:
 - a. the underlined age may be increased (19–30); and
 - b. the bracketed references to Group Policyholder/Participating Organization may reflect either or both as applicable.
 - 4. The bracketed text at the end of the first paragraph regarding a QMCSO may be omitted if not applicable.
 - 5. A "child" may include the bracketed "or grandchild" if requested by the group policyholder.
- E. The war exclusion amendment so that it may be included verbatim, if applicable, or omitted in its entirety.

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL000000000000 has been issued to
The Recreational and Welfare Association, Inc. of the National Institute of Health
(The Group Policyholder)

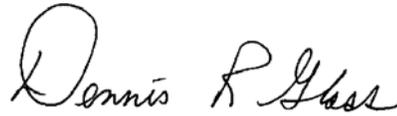
The Issue Date of the Policy is Month Day, Year.

Certificate of Insurance for [for Plan 1/ Class 1]

[Insured Person's Name]
[Insured Person's Effective Date]
[Certificate Number]

SPECIMEN

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. [If you have elected Dependent coverage on your enrollment form, your Dependents are covered under this Certificate only if such Dependents are eligible for insurance under the Policy and the required premium has been paid.] This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.



President

LIMITED BENEFIT, PLEASE READ CAREFULLY

**This is a limited benefit certificate. It provides accident only insurance coverage.
There is no coverage for hospital, medical-surgical or major medical expenses.**

CERTIFICATE OF GROUP ACCIDENT INSURANCE

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SPECIMEN

[ABC Company, Incorporated]
[000000000000]

SCHEDULE OF BENEFITS

[For Plan 1/ Class 1]

ELIGIBLE CLASS means: All Full-Time Employees who are members in good standing with the Group Policyholder

[ANNUAL/OPEN ENROLLMENT PERIOD: November 15 – December 14]

ELIGIBILITY WAITING PERIOD (For date insurance begins, refer to "Effective Dates" section.)
30 days

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

EMERGENCY CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Ambulance Transportation	[\$50-500]
Air Ambulance Transportation	[\$200-2,500]
Emergency Care Treatment	[\$10-400]
Initial Physician Office Visit	[\$10-200]
Major Diagnostic Exam	[\$50 - 1,500]

TREATMENT CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Hospital Admission	[\$100-3,000]
Hospital Confinement	[\$50-1,000]
Intensive Care Unit (ICU) Confinement	[\$50-1,000]
Alternate Care and Rehabilitative Facility Confinement	[\$40-1,000]
Follow-up Care	[\$10-100]
Transportation	[\$50-900]
Lodging	[\$50-350]
Family Care	[\$10 - 200]

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS

Type of Injury/Treatment

Benefit Amount

Fractures

Non Surgical

Surgical

Ankle	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Arm (shoulder to elbow)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Arm (elbow to wrist)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Bones of Face (except those listed below)	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Coccyx	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Collarbone	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Elbow	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Finger	[<u>\$10-2,000</u>]	[<u>\$10-2,000</u>]
Foot (except toes)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Hand (except fingers)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Hip	[<u>\$100-8,000</u>]	[<u>\$100-8,000</u>]
Kneecap	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Leg (hip to knee)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Leg (knee to ankle)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Lower Jaw	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Nose	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Pelvis	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Rib	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Shoulder blade	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Skull (depressed)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Skull (non-depressed)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Sternum	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Toe	[<u>\$10-2,000</u>]	[<u>\$10-2,000</u>]
Upper Jaw	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Vertebrae	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Vertebral Column	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Wrist	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]

Chip Fracture	[<u>10-50% of the amount payable for full fracture</u>]
Multiple Fractures	[<u>Highest amount of 2 – 10 fractures sustained</u>]

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>	
	<u>Non-Surgical</u>	<u>Surgical</u>
Dislocations		
Ankle	[\$50-5,000]	[\$50-5,000]
Collarbone (sternoclavicular)	[\$50-5,000]	[\$50-5,000]
Collarbone (acromio and separation)	[\$50-3,000]	[\$50-3,000]
Elbow	[\$50-3,000]	[\$50-3,000]
Finger	[\$10-2,000]	[\$10-2,000]
Foot (except toes)	[\$50-5,000]	[\$50-5,000]
Hand (except fingers)	[\$50-5,000]	[\$50-5,000]
Hip	[\$100-12,000]	[\$100-12,000]
Knee (not kneecap)	[\$50-5,000]	[\$50-5,000]
Lower Jaw	[\$50-5,000]	[\$50-5,000]
Shoulder	[\$50-5,000]	[\$50-5,000]
Toe	[\$10-2,000]	[\$10-2,000]
Wrist	[\$50-5,000]	[\$50-5,000]
Partial Dislocation	[10-50% of benefit payable for Dislocation]	
Multiple Dislocations	[Highest amount of 2 - 10 dislocations sustained]	
Combination of Dislocation(s) and Fracture(s)	[Highest amount of 2 - 10 dislocations or fractures sustained]	
Transfusions: Blood, Plasma, Platelets	[\$25-900]	
Burns		
<u>2nd Degree</u>		
< 9%	[\$100-800]	
10-18%	[\$100-2,500]	
19-36%	[\$200-5,000]	
37% +	[\$300-8,000]	
<u>3rd Degree</u>		
< 9%	[\$300-8,000]	
10-18%	[\$500-13,000]	
19-36%	[\$800-25,000]	
37% +	[\$1,000-50,000]	
Skin Grafts (due to burns)	[10-50% of benefit payable for Burns]	

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>
Coma	[\$200-15,000]
Concussion	[\$10-500]
Dental Injury - Emergency Dental Work for the following:	
Crown	[\$10-500]
Extraction	[\$10-300]
Eye Injury	
Surgical repair	[\$20-900]
Removal of foreign body	[\$20-700]
Joint Replacement	
Hip	[\$500-15,000]
Knee	[\$500-15,000]
Shoulder	[\$500-15,000]
Lacerations	
No Sutures Required	[\$5-500]
Sutures Required (Total Length of all Sutured Lacerations)	
1-5cm:	[\$10-800]
5.1-5.5cm:	[\$25-2,000]
5.6cm+:	[\$50-3,000]
Knee Cartilage	[\$50-2,500 per repair]
Ligaments/Tendons/Rotator Cuff	[\$50-2,500 per repair]
Ruptured Disc	[\$50-2,500]
Surgery – Abdominal or Thoracic	[\$100-3,000]
Surgery – Arthroscopic	[\$100-800]

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

TRANSITIONAL CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Medical Appliance Assistance	
Crutches	[<u>\$10-100</u>]
Wheelchair – expected use less than 1 year	[<u>\$50-250</u>]
Wheelchair – expected use 1 year or longer	[<u>\$200-2,000</u>]
Walker – expected use less than 1 year	[<u>\$10-100</u>]
Walker – expected use 1 year or longer	[<u>\$50-250</u>]
Other Medical Appliance used for mobility	[<u>\$10-100</u>]
Prosthesis	[<u>\$200-5,000 per device</u>]
Reasonable Modifications	[<u>\$500-15,000</u>]

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

ACCIDENTAL [DEATH and] DISMEMBERMENT BENEFITS [AD&D]

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Loss	
Loss of Life	[<u>\$5,000-200,000</u>]
Loss of Hand, Foot, Arm, Leg, Eye, or Hearing in One Ear	[<u>\$2,000-40,000</u>]
Any Loss of finger, thumb, or toe	[<u>\$50-2,500</u>]
Common Carrier Accident	[<u>1-2 times AD&D Benefit Amount/\$10,000-300,000</u>]
Common Disaster	[<u>1.5-3 times AD&D Benefit Amount</u>]
Transportation of Remains	[<u>\$3,000-20,000</u>]
Seat Belt/Helmet	[<u>5-15% of AD&D Benefit Amount</u>]
Catastrophic Loss	[<u>\$5,000-150,000</u>]
Loss of Sight in Both Eyes	
Loss of Hearing in Both Ears	
Loss of Speech	
Loss of Both Arms and Both Legs	
Loss of Both Arms	
Loss of Both Legs	
Loss of Arm and Leg	

SPECIMEN

DEFINITIONS

ACCIDENT or **ACCIDENTAL** refers to an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

ACTIVE WORK or **ACTIVELY AT WORK** means a member of the Group Policyholder who is engaged in employment on a full-time basis for the Minimum Hours shown in the Schedule of Insurance and performing all customary duties of his or her occupation.

Unless disabled on the prior workday or on the day of absence, a member will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday; or
- (2) a paid vacation day, or other scheduled or unscheduled non-workday.

AIRCRAFT means any device used for aerial navigation, including but not limited to, airplanes, helicopters, balloons, gliders, parachutes, hang gliders and parasails.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible members to purchase or make changes to their Personal or Dependent Accident Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period.

CHIP FRACTURE means a fracture in which a piece of the bone is broken off.

CHILD CARE CENTER means any facility which:

- (1) is licensed or approved by the state;
- (2) provides non-medical care and supervision for children in a group setting; and
- (3) is not operated by the Insured Person or a member of the Insured Person's immediate family.

COMA means a state of complete mental unresponsiveness, due to Injury, with no evidence of appropriate responses to stimulation, as diagnosed by a Physician.

COMMON CARRIER means any land, air or water conveyance operated under a license to transport passengers for hire.

COMMON CARRIER ACCIDENT means a Covered Accident while the Insured Person [or Insured Dependent] is a fare-paying passenger on a Common Carrier.

COMPANION means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

COVERED ACCIDENT means an Accident that:

- (1) occurs while the Insured Person's [or Insured Dependent's] coverage under the Policy is in effect;
- (2) results in an Injury; and
- (3) is not otherwise excluded under the terms of the Policy.

**DEFINITIONS
(Continued)**

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the Group Policyholder's place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

DEPENDENT ACCIDENT INSURANCE means the coverage provided by the Policy for eligible Dependents.

DISLOCATION means a completely separated joint. A Partial Dislocation means that the joint is misaligned, but not completely dislocated, as diagnosed by a Physician.

ELIGIBILITY WAITING PERIOD means the period of time a member is in good standing with the Group Policyholder, before he or she becomes eligible to enroll for insurance under the Policy.

EMERGENCY CARE FACILITY means an emergency room or urgent care facility recognized by the laws of the state where located.

FRACTURE means a broken bone that can be determined by a diagnostic exam.

FULL-TIME EMPLOYEE means a person:

- (1) whose employment with the U.S. Federal Government is the person's main occupation;
- (2) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
- (3) who is a member of an eligible class under the Policy; and
- (4) who is a citizen of the United States or legally works in the United States.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of the Policy.

HOME HEALTH CARE AGENCY means an agency that provides skilled nursing and other home health care services according to state and/or local laws on a visiting basis in the Insured Person's temporary or principal place of residence.

HOSPITAL means a general hospital which:

- (1) is licensed, approved or certified by the state where it is located;
- (2) is recognized by the Joint Commission;
- (3) is operated to treat Inpatients;
- (4) has a registered nurse always on duty; and
- (5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:

- (1) is specialized solely in dentistry, mental illness or substance abuse;
- (2) is a rest home, home for the aged, convalescent home or nursing home; or
- (3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

HOSPITAL CONFINEMENT means being a registered bed patient in a Hospital upon a Physician's recommendation. Such confinement must be medically necessary to diagnose or treat a covered Injury.

INPATIENT means an Insured Person [or Insured Dependent] who is an overnight resident patient.

**DEFINITIONS
(Continued)**

INSURANCE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
 - (2) ending at 12:00 midnight on the last day of the same calendar month;
- at the Group Policyholder's primary place of business.

INSURED DEPENDENT means a Dependent for whom Policy coverage is in effect.

INSURED PERSON means a Person for whom Policy coverage is in effect.

INJURY OR INJURIES means bodily injury solely due to an Accident. It includes all complications of and all injuries received from the same Covered Accident.

INTENSIVE CARE UNIT (ICU) means a designated part of a Hospital that:

- (1) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
- (3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- (4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
- (5) is assigned a Physician on a full-time basis.

LOSS, as used in the Dismemberment and Catastrophic Loss Benefits, means severance or loss of function:

- (1) of the hand through or above the wrist joint;
- (2) of the foot through or above the ankle joint;
- (3) of the arm above the elbow;
- (4) of the leg above the knee;
- (5) of sight in one eye, total and permanent loss of sight;
- (6) of hearing, deafness in an ear that cannot be corrected to any functional degree by any procedure, aid or device;
- (7) of speech, the loss of audible communication such that it cannot be corrected to any functional degree by any procedure, aid or device;
- (8) of a finger or a thumb; or
- (9) of a toe.

Loss of function means the total and irrevocable loss of use.

MEDICAL HEALTH PROFESSIONAL means a person, other than a Physician, that renders medical care and performs services that are within the scope of such person's license. Included in this definition are registered nurses, physician's assistants, and nurse practitioners.

OBSERVATION UNIT means a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician and which:

- (1) is under the direct supervision of a Physician or registered nurse;
- (2) is staffed by nurses assigned specifically to that unit; and
- (3) provides care seven days per week, 24 hours per day.

OCCUPATIONAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice occupational therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Occupational Therapy Association.

DEFINITIONS
(Continued)

OUTPATIENT TREATMENT means medical services that an Insured Person [or Insured Dependent] receives when not confined as an Inpatient in a Hospital.

PERSON means a Full-Time federal Employee who is a member in good standing with the Group Policyholder[:]

- (1) who is a member of a class that is eligible for insurance under the Policy[; and]
- (2) who has completed an enrollment form].

PERSONAL ACCIDENT INSURANCE means the insurance provided by the Policy for Insured Persons.

PHYSICAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice physical therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Physical Therapy Association.

PHYSICIAN means:

- (1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
- (2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:

- (1) the Insured Person's spouse, [domestic partner, civil union partner], siblings, parents, children and grandparents; and
- (2) his or her spouse's [, domestic partners, or civil union partner's] relatives of like degree.

POLICY means the Group Accident Insurance Policy issued by the Company to the Group Policyholder.

SICKNESS means

- (1) illness;
- (2) pregnancy; or
- (3) infection, except when the infection is due to an Accidental cut or wound.

TERRORISM means activities against persons, organizations or property of any nature if such activities involve the following or preparation for the following:

- (1) use or threat of force or violence;
- (2) commission or threat of a dangerous act; or
- (3) commission or threat of an act that interferes with or disrupts an electronic, communication, information or mechanical system; and

when one or both of the following applies:

- (1) the effect is to intimidate or coerce a government or the civilian population or any segment thereof, or to disrupt any segment of the economy; or
- (2) it appears that the intent is to intimidate or coerce a government, or to further political, ideological, religious, social or economic objectives or to express (or to express opposition to) a philosophy or ideology.

YOU and YOUR means an eligible Employee for whom the coverage provided by the Policy is in effect.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:

- (1) the Policy and any amendments to it; and
- (2) the Group Policyholder's application.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons [or Insured Dependents] are representations and not warranties. No statement made by an Insured Person [or Insured Dependent] will be used to contest the insurance provided by the Policy, unless:

- (1) it is contained in a written statement signed by that Insured Person [or Insured Dependent]; and
- (2) a copy of the statement has been furnished to that Insured Person [or Insured Dependent].

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person [or Insured Dependent], after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:

- (1) the Policy's eligibility requirements, exclusions and limitations; and
- (2) other Policy provisions unrelated to the validity of insurance.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person [or Insured Dependent] were misstated:

- (1) a fair adjustment of the premium will be made; and
- (2) the true facts will decide if and in what amount insurance is valid under the Policy.

If any Insured Person's [or Insured Dependent's] age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:

- (1) Workers' Compensation laws; or
- (2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Certificate may not be assigned.

**ELIGIBILITY AND EFFECTIVE DATES FOR
PERSONAL ACCIDENT INSURANCE**

ELIGIBILITY. A Person becomes eligible for insurance provided by the Policy on the [later/latest of]:

- (1) the Policy's date of issue; or
- (2) the date the Waiting Period is completed.

ENROLLMENT. A Person may enroll for Personal Accident Insurance only:

- (1) when first eligible; or
- (2) during any Annual/Open Enrollment Period.

EFFECTIVE DATE. Personal Accident Insurance becomes effective on the latest of:

- (1) the date you become eligible for the insurance;
- (2) the date you resume Active Work, if not Actively at Work on the day your insurance would otherwise take effect; or
- (3) if you contribute to the cost of the Personal Accident Insurance, the date you make written application for insurance and pay the required premium to the Company.

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date on which you become eligible for the increase, if Actively at Work on that day; or
- (2) the day you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any reduction in insurance or benefits will take effect on the day of the change, whether or not you are Actively at Work.

ANNUAL/OPEN ENROLLMENT PERIOD. You gain become eligible to enroll, re-enroll, or change benefit options for Personal Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

SPECIMEN

TERMINATION OF PERSONAL ACCIDENT INSURANCE

TERMINATION. Your insurance will terminate at 12:00 midnight on the earliest of:

- (1) the date the Policy terminates (but without prejudice to any claim incurred prior to termination.);
- (2) the date your Class is no longer eligible for insurance;
- (3) the date you cease to be a member of the Eligible Class;
- (4) the last day of the Insurance Month in which you request termination;
- (5) the last day of the last Insurance Month for which premium payment is made on your behalf;
- (6) the end of the period for which the last required premium has been paid;
- (7) with respect to any particular insurance benefit, the date the portion of the Policy providing that type of benefit terminates;
- (8) the date your membership with the Group Policyholder terminates; or
- (9) the date you enter armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

PORTABILITY. If insurance under the Policy would end for any reason other than nonpayment of premiums, you have the option to continue Personal Accident Insurance and Dependent Accident Insurance. To continue insurance under this section, you must:

- (1) notify the Company within 31 days of the date the insurance would otherwise end; and
- (2) pay the applicable premium to the Company.

Portability is not available when insurance terminates solely because your spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earliest of:

- (1) the last day of the period for which you paid premiums; or
- (2) the date the Company receives a written request from you to terminate the insurance.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while you were insured under the Policy.

SPECIMEN

**ELIGIBILITY AND EFFECTIVE DATES FOR
DEPENDENT ACCIDENT INSURANCE**

DEPENDENT means your:

- (1) legal spouse, who is not legally separated from you;
- (2) unmarried child less than 19 years of age; [or]
- [(3) unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or]
- (4) unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability;
and
 - (b) chiefly dependent upon you for support and maintenance.

The child must be covered by the Group Policyholder's Accident plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:

- (a) within 31 days of the day insurance would otherwise end due to age; and
- (b) thereafter, when the Company requests (but not more than once every two years).

[Dependent will also include a child that you are required to provide insurance under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).]

"Child" includes:

- (1) your natural child or legally adopted child;
- (2) a child placed with you for the purpose of adoption from the date of placement;
- (3) a child for whom you are required by court order to provide accident insurance;
- (4) a stepchild [or grandchild] who resides in your household and who is chiefly dependent on you for support; and
- (5) a foster child:
 - (a) who resides in your household;
 - (b) who is chiefly dependent on you for support; and
 - (c) for whom you have assumed full parental responsibility and control.

ELIGIBILITY. You become eligible to enroll for Dependent Accident Insurance on the latest of:

- (1) the date you become eligible for Personal Accident Insurance;
- (2) the issue date of the Policy; or
- (3) the date you first acquire a Dependent.

You again become eligible to enroll for Dependent Accident Insurance under the Policy during any Annual/Open Enrollment Period.

You must be insured for Personal Accident Insurance to insure your Dependents. [Dependents to be insured by the Policy must be enrolled in the same plan of benefits as you.]

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Dependent Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

**ELIGIBILITY AND EFFECTIVE DATES FOR
DEPENDENT ACCIDENT INSURANCE
(Continued)**

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Accident Insurance will become effective on the latest of:

- | | |
|-----|--|
| (1) | the first day of the <u>Insurance Month</u> coinciding with or next following the date you become eligible for Dependent Accident Insurance; or |
| (2) | the first day of the <u>Insurance Month</u> coinciding with or next following the date you make written application for Dependent Accident Insurance; and pay the required Dependent premium to the Company. |

COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires you to provide Accident benefits for the child, the insurance will become effective on the date stated in the court order; subject to payment of any additional premium.

NEW DEPENDENTS. If additional premium is required to add a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) you complete a written application; and
- (2) the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

If additional premium is not required, coverage for a new Dependent will become effective on the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically insured for the first 31 days following birth. If you elect not to enroll the newborn child and pay any additional premium within 31 days following birth, the newborn child's insurance will terminate.

SPECIMEN

**TERMINATION OF
DEPENDENT ACCIDENT INSURANCE**

TERMINATION. Accident Insurance on a Dependent will cease on the date he or she ceases to be an eligible Dependent, as defined in the Policy.

Dependent Accident Insurance will cease for all your Insured Dependents on the earliest of:

- (1) the date your Accident Insurance terminates;
- (2) the date Dependent Accident Insurance is discontinued under the Policy;
- (3) the date you cease to be in a class eligible for Dependent Accident Insurance;
- (4) the date you request that the Dependent Accident Insurance be terminated;
- (5) with respect to a benefit or a specific type of benefit, the date the portion of the Policy providing that type of benefit terminates; or
- (6) the date through which premium has been paid on behalf of the Insured Dependents.

SURVIVING DEPENDENTS. If Personal Accident Insurance terminates due to your death, Dependent Accident Insurance may be continued:

- (1) for three Insurance Months; or any longer period, if required by state or federal law;
- (2) provided the Group Policyholder submits the premium on behalf of the surviving Dependents; and the Policy remains in force.

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while the Insured Dependent was insured under the Policy.

SPECIMEN

EMERGENCY CARE BENEFITS

The Company will pay [one or more of] the following emergency care benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

AMBULANCE TRANSPORTATION. The Company will pay an Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by ground transportation to or from a Hospital or between medical facilities, for treatment of Injuries sustained as a result of a Covered Accident. The ambulance transportation must be within 90 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

AIR AMBULANCE TRANSPORTATION. The Company will pay an Air Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by air ambulance to or from a Hospital or between medical facilities for treatment of Injuries sustained as the result of a Covered Accident. The air ambulance transportation must be within 48 hours of the Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit may be paid in addition to the Ambulance Transportation benefit.

EMERGENCY CARE TREATMENT. The Company will pay an Emergency Care Treatment benefit if you [or your Insured Dependent] [are/is] examined or treated in an Emergency Care Facility as a result of a Covered Accident. The emergency care treatment must be received within 72 hours of a Covered Accident. This benefit will be paid once per person per Covered Accident.

INITIAL PHYSICIAN OFFICE VISIT. The Company will pay an Initial Physician Office Visit benefit if you [or your Insured Dependent] [are/is] examined or treated by a Physician or Medical Health Professional in an office of practice as a result of a Covered Accident. The examination or treatment must be administered within 60 days of a Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit will not be payable if you [or your Insured Dependent] receive[s] payment for the Emergency Care Treatment benefit, as described above.

MAJOR DIAGNOSTIC EXAM. The Company will pay a Major Diagnostic Exam benefit if you or an Insured Dependent undergoes one of the following major diagnostic exams as a result of a Covered Accident:

- (1) a computed tomography (CT or CAT) scan;
- (2) a magnetic resonance imaging (MRI);
- (3) a positron emission tomography (PET) scan;
- (4) an electroencephalography (EEG);
- (5) a spectroscopy (SPECT);
- (6) a joint imaging scan;
- (7) a diffusion tensor imaging (DTI) scan; or
- (8) a magnetic resonance angiogram (MRA) scan.

A major diagnostic exam must be prescribed by a Physician and performed within 60 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

TREATMENT CARE BENEFITS

The Company will pay [one or more of] the following treatment care benefit[s] if you [or your Insured Dependent] meet the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

HOSPITAL ADMISSION. The Company will pay a Hospital Admission benefit if you [or your Insured Dependent] [are/is] admitted to a Hospital as a result of a Covered Accident. The admission must occur within 180 days of a Covered Accident. The Company will not pay this benefit for emergency room treatment, Outpatient Treatment, or a stay of less than 20 hours in an Observation Unit. This benefit is payable once per person per Covered Accident.

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement benefit for each day you [or your Insured Dependent] [are/is] confined in a Hospital as the result of a Covered Accident. The initial confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 365 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accident. In the event this Hospital Confinement benefit and an Intensive Care Unit Confinement Benefit are payable on the same day, only the Intensive Care Unit Confinement benefit will be paid.

INTENSIVE CARE UNIT (ICU) CONFINEMENT. The Company will pay an ICU Confinement benefit for each day or partial day you [or your Insured Dependent] [are/is] confined in an ICU as the result of a Covered Accident. The confinement must begin within 30 days of a Covered Accident. The ICU confinement period begins on the day of admission to the ICU and ends on the day of discharge from the ICU. This benefit will be paid for up to 15 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one ICU Confinement at a time, even if it is caused by more than one Covered Accident. In the event this ICU Confinement benefit and the Hospital Confinement benefit are payable on the same day, only the ICU benefit will be paid. If you [or your Insured Dependent] exhaust[s] the ICU benefit but is still confined, you [or your Insured Dependent] may be eligible for the Hospital Confinement benefit.

ALTERNATE CARE AND REHABILITATIVE FACILITY CONFINEMENT. The Company will pay an Alternate Care or Rehabilitative Facility Confinement benefit for each day you [or your Insured Dependent] [are/is] confined on an Inpatient basis in an Alternate Care or Rehabilitative Facility as a result of a Covered Accident. The confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 90 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Alternate Care or Rehabilitative Facility Confinement at a time, even if it is caused by more than one Covered Accident. The Alternate Care and Rehabilitative Facility Confinement benefit will not be paid on any day when the Hospital or ICU Confinement benefit is paid.

FOLLOW-UP CARE. The Company will pay a Follow-Up Care benefit for each occurrence of follow-up care for Physician treatment, physical therapy, occupational therapy, or home health care that result from Injuries sustained by you [or your Insured Dependent]. Follow-up care must be received within 365 days of a Covered Accident. Follow-up care must be provided by a Physician, Medical Health Professional, Physical Therapist, Occupational Therapist or a Home Health Care Agency. This benefit is payable for up to 6 times per person per Covered Accident. This benefit is not payable while you [or your Insured Dependent] [are/is] confined in a Hospital, ICU, or an Alternate Care or Rehabilitative Facility.

TRANSPORTATION. The Company will pay a Transportation benefit when you [or your Insured Dependent] must travel more than 100 miles one way for treatment at a Hospital or other specialized freestanding treatment facility. The treatment must be prescribed by a Physician and not available locally. This benefit is payable up to three times per person per Covered Accident. This benefit is not payable when transportation is provided by ambulance or air ambulance.

TREATMENT CARE BENEFITS
(Continued)

LODGING. The Company will pay a Lodging benefit for each day a Companion accompanies you [or your Insured Dependent] who is Hospital confined more than 100 miles from your [or your Insured Dependent's] principal place of residence due to a Covered Accident. The Companion must stay in a hotel, motel or Hospital-sponsored hospitality suite. This benefit is payable for up to 30 days, within 365 days of the Covered Accident.

FAMILY CARE. The Company will pay the Family Care Benefit if:

- (1) you [or your Insured Dependent] [are/is] confined in a Hospital, ICU or Alternate Care or Rehabilitative Facility as a result of a Covered Accident; and
- (2) you have a child or children attending a Child Care Center.

This benefit is payable for each child attending a Child Care Center on any given day you [or your Insured Dependent] [are/is] confined. The child attending a Child Care Center does not need to be insured under the Policy for this benefit to be payable but must meet the definition of Child in the Eligibility and Effective Dates for Dependent Accident Insurance provision. This benefit is payable for up to 30 days, within 365 days of the Covered Accident. The Company will pay only one Family Care benefit per child.

SPECIMEN

SPECIFIC INJURIES OR TREATMENTS

The Company will pay [one or more of] the following specific injuries or treatments benefit[s] if you [or your Insured Dependent] meet the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

FRACTURE. The Company will pay a Fracture benefit when you or an Insured Dependent sustains a Fracture or Chip Fracture as a result of a Covered Accident. The Fracture or Chip Fracture must be diagnosed by a Physician within 90 days of a Covered Accident.

DISLOCATION. The Company will pay a Dislocation benefit when you or an Insured Dependent sustains a Dislocation or Partial Dislocation as a result of a Covered Accident. The Dislocation or Partial Dislocation must be diagnosed by a Physician within 90 days of a Covered Accident.

BLOOD, PLASMA, PLATELETS. The Company will pay a benefit for your [or your Insured Dependent's]:

- (1) transfusion;
- (2) administration;
- (3) cross-matching; or
- (4) typing and processing;

of blood, plasma, or platelets administered as a result of a Covered Accident, provided this is done within 90 days of such Covered Accident. This benefit is payable once per person per Covered Accident.

BURNS. The Company will pay a Burn benefit when you [or your Insured Dependent] sustain[s] a 2nd or 3rd degree burn as a result of a Covered Accident. The 2nd or 3rd degree burn must be treated by a Physician within 72 hours of a Covered Accident. If the burns meet more than one of the Burn Benefit classifications shown in the Schedule of Benefits, the Company will pay a single highest benefit amount. This benefit is payable once per person per Covered Accident.

SKIN GRAFT. The Company will pay a Skin Graft benefit when grafting of the skin is necessary for a burn that was payable under the Burn Benefit. This benefit is payable once per person per Covered Accident.

COMA. The Company will pay a Coma benefit if you [or your Insured Dependent] [have/has] been in a Coma for 15 or more days as a result of a Covered Accident. This benefit is payable once per person per Covered Accident.

CONCUSSION. The Company will pay a Concussion benefit if you [or your Insured Dependent] sustain[s] a concussion as a result of a Covered Accident. The concussion must be diagnosed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

DENTAL INJURY. The Company will pay a Dental Injury benefit if your [or your Insured Dependent's] natural teeth are damaged and:

- (1) extracted; or
- (2) repaired by placement of a crown;

by a Dentist as a result of a Covered Accident. Initial treatment must be received within 7 days of a Covered Accident. This benefit is payable for up to one crown and one extraction per person per Covered Accident, regardless of the number of teeth involved.

SPECIFIC INJURIES OR TREATMENTS
(Continued)

EYE INJURY. The Company will pay an Eye Injury benefit if you [or your Insured Dependent] injure[s] an eye (or eyes) in a Covered Accident and:

- (1) surgical repair is performed by a Physician within 90 days of a Covered Accident; or
- (2) a Physician removes an embedded foreign body from your [or your Insured Dependent's] eye, with or without anesthesia, within 90 days of a Covered Accident.

This benefit is payable once for each eye per person per Covered Accident.

JOINT REPLACEMENT. The Company will pay a Joint Replacement benefit when you [or your Insured Dependent] sustain[s] an Injury requiring a hip, knee, or shoulder joint replacement as a result of a Covered Accident. The joint replacement must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable for each required replacement per person per Covered Accident.

LACERATION. The Company will pay a Laceration benefit when you [or your Insured Dependent] sustain[s] a laceration as a result of a Covered Accident. The laceration must be treated by a Physician or Medical Health Professional within 72 hours of a Covered Accident. This benefit is payable:

- (1) once for lacerations not requiring sutures, regardless of the number; and
- (2) once for the total length of all lacerations requiring sutures;

per person as a result of any one Covered Accident.

KNEE CARTILAGE. The Company will pay a Knee Cartilage benefit when you [or your Insured Dependent] sustain[s] an Injury requiring the surgical repair or removal of torn knee cartilage as a result of a Covered Accident. The surgical repair or removal must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

TENDON/LIGAMENT/ROTATOR CUFF. The Company will pay the Tendon/Ligament/Rotator Cuff benefit when you [or your Insured Dependent] require[s] surgical repair of:

- (1) tendons;
- (2) ligaments; or
- (3) the muscles and tendons that make up the rotator cuff;

as a result of a Covered Accident. The surgical repair must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

RUPTURED DISC. The Company will pay the Ruptured Disc benefit when you [or your Insured Dependent] sustain[s] an Injury requiring surgical repair of a ruptured intervertebral disc as a result of a Covered Accident. The ruptured disc must be surgically repaired by a Physician within 90 days of a Covered Accident. This benefit is payable once per disc per person per Covered Accident.

SURGERY (ABDOMINAL OR THORACIC). The Company will pay the Surgery (Abdominal or Thoracic) benefit when you [or your Insured Dependent] undergo[es] abdominal or thoracic surgery as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

SURGERY (ARTHROSCOPIC). The Company will pay a Surgery (Arthroscopic) benefit when you [or your Insured Dependent] undergo[es] arthroscopic surgery, with no repair, as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSITIONAL CARE BENEFITS

The Company will pay [one or more of] the following transitional care benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

MEDICAL APPLIANCE ASSISTANCE. The Company will pay a benefit for Medical Appliances that are required by you [or your Insured Dependent] as a result of Injuries sustained in a Covered Accident. The Medical Appliance must be recommended by a Physician or Medical Health Professional and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the Physician or Medical Health Professional must recommend the Medical Appliance within two years of the Covered Accident. This benefit is payable once for any one Medical Appliance per person per Covered Accident.

Medical Appliance means an item that is intended by its manufacturer for use in directly substituting for a malfunctioning part of the body for assistance with mobility. Examples include crutches, wheel chairs and walkers.

PROSTHESIS. The Company will pay a benefit for functional prosthetic limbs that are required by you or an Insured Dependent as a result of Injuries sustained in a Covered Accident. The functional prosthetic limb must be prescribed by a Physician and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the prosthetic limb must be prescribed by a Physician and received within two years of the Covered Accident. This benefit is payable once per limb per person per Covered Accident.

REASONABLE MODIFICATIONS. The Company will pay a benefit for reasonable modifications made to you [or your Insured Dependent's]:

- (1) principal place of residence; or
- (2) vehicle;

provided you [or your Insured Dependent] suffered a Catastrophic Loss as described in the Schedule of Benefits. Modifications must be made within two years from the date of the Covered Accident. This benefit is payable once per person per Covered Accident.

SPECIMEN

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The Company will pay [one or more of] the following AD&D benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH OR DISMEMBERMENT. The Company will pay an Accidental Death or Dismemberment benefit when you [or your Insured Dependent] sustain[s] an Injury that causes death or dismemberment as a result of a Covered Accident. The Injury must cause death or dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss.

The Accidental Dismemberment Benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when you [or your Insured Dependent] sustain[s] a Common Carrier Accident that results in your [or your Insured Dependent's] death or dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSPORTATION OF REMAINS. The Company will pay a Transportation of Remains benefit if you [or your Insured Dependent] die[s] at least 100 miles from your [or your Insured Dependent's] principal place of residence as a result of a Covered Accident, and the bodily remains or ashes are returned:

- (1) by a company that provides mortuary transport services; and
- (2) to a mortuary or funeral home within 30 miles of the deceased's principal place of residence.

The Company will pay for only one Transportation of Remains benefit per person.

A benefit payable for the transportation of your remains will be paid in accord with the Beneficiary provision. [A benefit payable for the transportation of your Insured Dependent's remains will be paid to you.]

SEAT BELT/HELMET. If you [or your Insured Dependent]:

- (1) [were/was] wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) suffer[s] an AD&D loss;

the Accidental Death or Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

COMMON DISASTER. The Company will pay a Common Disaster benefit if both you and your Insured Dependent Spouse:

- (1) is Injured in the same Covered Accident; and
- (2) lose your lives as a direct result of such Injuries within 365 days of the Common Accident.

The Common Disaster benefit increases your Insured Dependent Spouse's benefit for Accidental loss of life to equal the your Accidental Death Benefit.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when you [or your Insured Dependent] sustain[s] an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment Benefit will not be paid for the same or attached body part.

ACCIDENTAL DISMEMBERMENT BENEFITS

The Company will pay one or more of the following accidental dismemberment benefits if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DISMEMBERMENT. The Company will pay an Accidental Dismemberment benefit when you [or your Insured Dependent] sustain[s] an Injury that causes a dismemberment as a result of a Covered Accident. The Injury must cause dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss

The Accidental Dismemberment Benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when you [or your Insured Dependent] sustain[s] a Common Carrier Accident that results in your [or your Insured Dependent's] dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

SEAT BELT/HELMET. If you [or your Insured Dependent]:

- (1) [were/was] wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) [suffer/suffers] an Accidental Dismemberment;

the Accidental Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when you [or your Insured Dependent] sustain[s] an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

SPECIMEN

LIMITATIONS AND EXCLUSIONS

The Policy covers only Injuries that occur while insurance is in force. Benefits are not payable for any loss if the loss resulting, directly or indirectly, from or was in any degree caused by:

- (1) disease, physical or mental infirmity, Sickness, or medical or surgical treatment of these;
- (2) intentional self-inflicted injury or self-destruction, or any attempt thereof; suicide or suicide attempt, whether sane or insane;
- (3) deliberate use of drugs, poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, except when administered within the therapeutic levels and dosage prescribed by a licensed Physician;
- (4) participation in, commission of or attempt to commit a felony;
- (5) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind; [or Terrorism or any act of Terrorism;]
- (6) duty as a member of any military, including Reserves or National Guard;
- (7) travel or flight in or on any Aircraft, except:
 - (a) as a fare-paying passenger on a regularly scheduled commercial flight; [or
 - (b) as a passenger or pilot in the Group Policyholder's aircraft while flying on the Group Policyholder's business provided:
 - (i) the aircraft has a valid U.S. airworthiness certificate (or foreign equivalent); and
 - (ii) the pilot has a valid pilot's certificate with a non-student rating authorizing him to fly the aircraft];
- (8) your [or your Insured Dependent] having a blood alcohol level of .08 gram of alcohol or more per 100 milliliters of blood;
- [(9) Injury arising out of or in the course of any employment for wage or profit],
- (10) high risk sports or extreme sports such as, but not limited to, bungee jumping, parachuting, base jumping, or mountaineering;
- (11) cosmetic or elective surgery;
- (12) being incarcerated in any type of penal or detention facility;
- (13) participating in or practicing for, or officiating any semi-professional or professional sport;
- (14) riding in or driving in any motor driven vehicle for race, stunt show or speed test; or
- (15) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

SPECIMEN

BENEFICIARY

PAYMENTS TO BENEFICIARY. At your death, any amount payable as a result of your death will be paid to the named Beneficiary who survives you. If no named Beneficiary survives you, payment will be made to your estate or in accord with the Facility of Payment section.

PAYMENTS TO BENEFICIARY. At your death, any amount payable as a result of your death will be paid to the named Beneficiary who survives you. If you have not named a Beneficiary, or if no named Beneficiary survives you; then payment will be made to your:

- (1) surviving spouse[, domestic partner, or civil union partner]; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving sibling or siblings in equal shares; or, if none
- (5) estate.

If determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

- (1) within 15 days of your death; and
- (2) before the Company receives satisfactory proof of your death;

payment will be made as if you had survived that person, unless other provisions have been made.

NAMING THE BENEFICIARY. Your Beneficiary will be as shown on your enrollment form, unless changed. If the Policy replaces a group policy providing similar coverages; then your beneficiary named under the prior policy will be the beneficiary under the Policy, until changed.

CHANGING THE BENEFICIARY. Only you or your assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change [with the Company at its Group Insurance Service Office/Group Policyholder] prior to your death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under the Policy becomes payable to your estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

- (1) a person who has assumed the care and support of you or a Beneficiary;
- (2) a person who has incurred expense as a result of your last illness or death;
- (3) the personal representative of your estate; or
- (4) any person related by blood or marriage to you.

No payment made to anyone named above may exceed \$1,000. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's name and Policy number;
- (2) your name, address and certificate number, if available; and
- (3) the patient's name and relationship to you.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then you may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of services; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

- (1) the nature, date and cause of the claim;
- (2) a description of the services provided; and
- (3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

- (1) any study models, treatment records or charts;
- (2) copies of any x-rays or other diagnostic materials; and
- (3) any other items the Company may reasonably require.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While an Accident claim is pending, the Company may have the claimant examined:

- (1) by a Physician of its choice;
- (2) as often as is reasonably required.

Any such exam will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Accident Benefits payable under this Certificate will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE

Accidental Death & Dismemberment. Benefits due to loss of your life will be paid in accord with the Beneficiary provision. All other benefits will be paid to you.

[Other] Accident Benefits. Any [other] Accident Benefits will be paid to you; unless[:]

- [(1)] an overpayment has been made and the Company is entitled to reduce future benefits; or
- [(2)] state or federal law requires that benefits be paid to an Insured Dependent child's custodial parent or custodian.]

CLAIM PROCEDURES FOR ACCIDENT INSURANCE
(Continued)

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within 90 days after receiving the first proof of [a death] [or other/an] Accident claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case, then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within 180 days after receiving the first proof of [a death] [or other/an] Accident claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of [a death] [or other/an] Accident claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, then the notice will also describe:

- (1) any further appeal procedures available under the Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

For [a death] [or other/an] Accident claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal, then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE
(Continued)

RIGHT OF RECOVERY If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) the claimant's receipt of benefits or services under another plan;
- (3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder [or Participating Organization], the Company has the authority to:

- (1) manage the Policy and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under the Policy.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering the Policy and claims under it;
- (2) determine eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

The claimant has the right to:

- (1) request a state insurance department review; or
- (2) bring legal action.

SPECIMEN

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL000000000000 has been issued to
Catholic Cemetery Conference
(The Group Policyholder)

The Issue Date of the Policy is Month Day, Year.

Participating Organization: XYZ Company

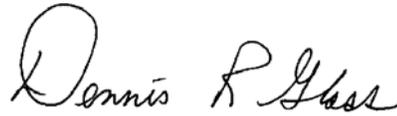
Participating Organization's Effective Date: _____

Certificate of Insurance for [for Plan 1/ Class 1]

[Insured Person's Name]
[Insured Person's Effective Date]
[Certificate Number]

SPECIMEN

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. [If you have elected Dependent coverage on your enrollment form, your Dependents are covered under this Certificate only if such Dependents are eligible for insurance under the Policy and the required premium has been paid.] This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.



President

READ YOUR CERTIFICATE CAREFULLY

**This is a limited benefit certificate. It provides accident only insurance coverage.
There is no coverage for hospital, medical-surgical or major medical expenses.**

CERTIFICATE OF GROUP ACCIDENT INSURANCE

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SPECIMEN

[ABC Company, Incorporated]
[000000000000]

SCHEDULE OF BENEFITS

[For Plan 1/ Class 1]

ELIGIBLE CLASS means: All Active Members

[ANNUAL/OPEN ENROLLMENT PERIOD: November 15 – December 14]

ELIGIBILITY WAITING PERIOD (For date insurance begins, refer to "Effective Dates" section.)
30 days

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

EMERGENCY CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Ambulance Transportation	[\$50-500]
Air Ambulance Transportation	[\$200-2,500]
Emergency Care Treatment	[\$10-400]
Initial Physician Office Visit	[\$10-200]
Major Diagnostic Exam	[\$50 - 1,500]

TREATMENT CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Hospital Admission	[\$100-3,000]
Hospital Confinement	[\$50-1,000]
Intensive Care Unit (ICU) Confinement	[\$50-1,000]
Alternate Care and Rehabilitative Facility Confinement	[\$40-1,000]
Follow-up Care	[\$10-100]
Transportation	[\$50-900]
Lodging	[\$50-350]
Family Care	[\$10 - 200]

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**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS

Type of Injury/Treatment

Benefit Amount

Fractures

Non Surgical

Surgical

Ankle	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Arm (shoulder to elbow)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Arm (elbow to wrist)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Bones of Face (except those listed below)	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Coccyx	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Collarbone	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Elbow	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Finger	[<u>\$10-2,000</u>]	[<u>\$10-2,000</u>]
Foot (except toes)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Hand (except fingers)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Hip	[<u>\$100-8,000</u>]	[<u>\$100-8,000</u>]
Kneecap	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Leg (hip to knee)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Leg (knee to ankle)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Lower Jaw	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Nose	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Pelvis	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Rib	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Shoulder blade	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Skull (depressed)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Skull (non-depressed)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Sternum	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Toe	[<u>\$10-2,000</u>]	[<u>\$10-2,000</u>]
Upper Jaw	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Vertebrae	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Vertebral Column	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Wrist	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]

Chip Fracture	[<u>10-50% of the amount payable for full fracture</u>]
Multiple Fractures	[<u>Highest amount of 2 – 10 fractures sustained</u>]

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>	
	<u>Non-Surgical</u>	<u>Surgical</u>
Dislocations		
Ankle	[\$50-5,000]	[\$50-5,000]
Collarbone (sternoclavicular)	[\$50-5,000]	[\$50-5,000]
Collarbone (acromio and separation)	[\$50-3,000]	[\$50-3,000]
Elbow	[\$50-3,000]	[\$50-3,000]
Finger	[\$10-2,000]	[\$10-2,000]
Foot (except toes)	[\$50-5,000]	[\$50-5,000]
Hand (except fingers)	[\$50-5,000]	[\$50-5,000]
Hip	[\$100-12,000]	[\$100-12,000]
Knee (not kneecap)	[\$50-5,000]	[\$50-5,000]
Lower Jaw	[\$50-5,000]	[\$50-5,000]
Shoulder	[\$50-5,000]	[\$50-5,000]
Toe	[\$10-2,000]	[\$10-2,000]
Wrist	[\$50-5,000]	[\$50-5,000]
Partial Dislocation	[10-10% of benefit payable for Dislocation]	
Multiple Dislocations	[Highest amount of 2 - 10 dislocations sustained]	
Combination of Dislocation(s) and Fracture(s)	[Highest amount of 2 - 10 dislocations or fractures sustained]	
Transfusions: Blood, Plasma, Platelets	[\$25-900]	
Burns		
<u>2nd Degree</u>		
< 9%	[\$100-800]	
10-18%	[\$100-2,500]	
19-36%	[\$200-5,000]	
37% +	[\$300-8,000]	
<u>3rd Degree</u>		
< 9%	[\$300-8,000]	
10-18%	[\$500-13,000]	
19-36%	[\$800-25,000]	
37% +	[\$1,000-50,000]	
Skin Grafts (due to burns)	[10-50% of benefit payable for Burns]	

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>
Coma	<u>[\$200-15,000]</u>
Concussion	<u>[\$10-500]</u>
Dental Injury - Emergency Dental Work for the following:	
Crown	<u>[\$10-500]</u>
Extraction	<u>[\$10-300]</u>
Eye Injury	
Surgical repair	<u>[\$20-900]</u>
Removal of foreign body	<u>[\$20-700]</u>
Joint Replacement	
Hip	<u>[\$500-15,000]</u>
Knee	<u>[\$500-15,000]</u>
Shoulder	<u>[\$500-15,000]</u>
Lacerations	
No Sutures Required	<u>[\$5-500]</u>
Sutures Required (Total Length of all Sutured Lacerations)	
1-5cm:	<u>[\$10-800]</u>
5.1-5.5cm:	<u>[\$25-2,000]</u>
5.6cm+:	<u>[\$50-3,000]</u>
Knee Cartilage	<u>[\$50-2,500 per repair]</u>
Ligaments/Tendons/Rotator Cuff	<u>[\$50-2,500 per repair]</u>
Ruptured Disc	<u>[\$50-2,500]</u>
Surgery – Abdominal or Thoracic	<u>[\$100-3,000]</u>
Surgery – Arthroscopic	<u>[\$100-800]</u>

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

TRANSITIONAL CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Medical Appliance Assistance	
Crutches	[\$10-100]
Wheelchair – expected use less than 1 year	[\$50-250]
Wheelchair – expected use 1 year or longer	[\$200-2,000]
Walker – expected use less than 1 year	[\$10-100]
Walker – expected use 1 year or longer	[\$50-250]
Other Medical Appliance used for mobility	[\$10-100]
Prosthesis	[\$200-5,000 per device]
Reasonable Modifications	[\$500-15,000]

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

ACCIDENTAL [DEATH and] DISMEMBERMENT BENEFITS [AD&D]

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Loss	
Loss of Life	[\$5,000-200,000]
Loss of Hand, Foot, Arm, Leg, Eye, or Hearing in One Ear	[\$2,000-40,000]
Any Loss of finger, thumb, or toe	[\$50-2,500]
Common Carrier Accident	[1-2 times AD&D Benefit Amount/\$10,000-300,000]
Common Disaster	[1.5-3 times AD&D Benefit Amount]
Transportation of Remains	[\$3,000-20,000]
Seat Belt/Helmet	[5-15% of AD&D Benefit Amount]
Catastrophic Loss	[\$5,000-150,000]
Loss of Sight in Both Eyes	
Loss of Hearing in Both Ears	
Loss of Speech	
Loss of Both Arms and Both Legs	
Loss of Both Arms	
Loss of Both Legs	
Loss of Arm and Leg	

SPECIMEN

DEFINITIONS

ACCIDENT or **ACCIDENTAL** refers to an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

ACTIVE MEMBER means a member in good standing with the Group Policyholder; who is not confined in a hospital or other health care facility on his or her effective date of coverage.

AIRCRAFT means any device used for aerial navigation, including but not limited to, airplanes, helicopters, balloons, gliders, parachutes, hang gliders and parasails.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible members to purchase or make changes to their Personal or Dependent Accident Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period.

CHIP FRACTURE means a fracture in which a piece of the bone is broken off.

CHILD CARE CENTER means any facility which:

- (1) is licensed as such by the state;
- (2) provides non-medical care and supervision for children in a group setting; and
- (3) is not operated by the Insured Person or a member of the Insured Person's immediate family.

COMA means a state of complete mental unresponsiveness, due to Injury, with no evidence of appropriate responses to stimulation, as diagnosed by a Physician.

COMMON CARRIER means any land, air or water conveyance operated under a license to transport passengers for hire.

COMMON CARRIER ACCIDENT means a Covered Accident while the Insured Person [or Insured Dependent] is a fare-paying passenger on a Common Carrier.

COMPANION means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

COVERED ACCIDENT means an Accident that:

- (1) occurs while the Insured Person's [or Insured Dependent's] coverage under the Policy is in effect;
- (2) results in an Injury; and
- (3) is not otherwise excluded under the terms of the Policy.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the [Group Policyholder's/Participating Organization's] place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

**DEFINITIONS
(Continued)**

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

DEPENDENT ACCIDENT INSURANCE means the coverage provided by the Policy for eligible Dependents.

DISLOCATION means a completely separated joint. A Partial Dislocation means that the joint is misaligned, but not completely dislocated, as diagnosed by a Physician.

ELIGIBILITY WAITING PERIOD means the period of time a Person must be in an eligible class with the Group Policyholder/Participating Organization, before he or she becomes eligible to enroll for insurance under the Policy.

EMERGENCY CARE FACILITY means an emergency room or urgent care facility recognized by the laws of the state where located.

FRACTURE means a broken bone that can be determined by a diagnostic exam.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of the Policy.

HOME HEALTH CARE AGENCY means an agency that provides skilled nursing and other home health care services according to state and/or local laws on a visiting basis in the Insured Person's temporary or principal place of residence.

HOSPITAL means a general hospital which:

- (1) is licensed, approved, or certified by the state where it is located;
- (2) is recognized by the Joint Commission;
- (3) is operated to treat inpatients;
- (4) has a registered nurse always on duty; and
- (5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:

- (1) is specialized solely in dentistry, mental illness or substance abuse;
- (2) is a rest home, home for the aged, convalescent home or nursing home; or
- (3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

HOSPITAL CONFINEMENT means being a registered bed patient in a Hospital upon a Physician's recommendation. Such confinement must be medically necessary to diagnose or treat a covered Injury.

INPATIENT means an Insured Person [or Insured Dependent] who is an overnight resident patient.

INSURANCE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
- (2) ending at 12:00 midnight on the last day of the same calendar month;

at the [Group Policyholder's/Participating Organization's] primary place of business.

INSURED DEPENDENT means a Dependent for whom Policy coverage is in effect.

INSURED PERSON means a Person for whom Policy coverage is in effect.

DEFINITIONS
(Continued)

INJURY OR INJURIES means bodily injury solely due to an Accident. It includes all complications of and all injuries received from the same Covered Accident.

INTENSIVE CARE UNIT (ICU) means a designated part of a Hospital that:

- (1) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
- (3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- (4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
- (5) is assigned a Physician on a full-time basis.

LOSS, as used in the Dismemberment and Catastrophic Loss benefits, means severance or loss of function:

- (1) of the hand through or above the wrist joint;
- (2) of the foot through or above the ankle joint;
- (3) of the arm above the elbow;
- (4) of the leg above the knee;
- (5) of sight in an eye, total and permanent loss of sight;
- (6) of hearing, deafness in an ear that cannot be corrected to any functional degree by any procedure, aid or device;
- (7) of speech, the loss of audible communication such that it cannot be corrected to any functional degree by any procedure, aid or device;
- (8) of a finger or a thumb; or
- (9) of a toe.

Loss of function means the total and irrevocable loss of use.

MEDICAL HEALTH PROFESSIONAL means a person, other than a Physician, that renders medical care and performs services that are within the scope of such person's license. Included in this definition are registered nurses, physicians assistants, and nurse practitioners.

OBSERVATION UNIT means a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician and which:

- (1) is under the direct supervision of a Physician or registered nurse;
- (2) is staffed by nurses assigned specifically to that unit; and
- (3) provides care seven days per week, 24 hours per day.

OCCUPATIONAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice occupational therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Occupational Therapy Association.

OUTPATIENT TREATMENT means medical services that an Insured Person [or Insured Dependent] receives when not confined as an Inpatient in a Hospital.

PERSON means an Active Member of the Group Policyholder[:]

- [(1)] who is a member of a class that is eligible for insurance under the Policy[; and]
- [(2)] who has completed an enrollment form].

PERSONAL ACCIDENT INSURANCE means the insurance provided by the Policy for Insured Persons.

**DEFINITIONS
(Continued)**

PHYSICAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice physical therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Physical Therapy Association.

PHYSICIAN means:

- (1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
- (2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment.

Relatives include:

- (1) the Insured Person's spouse, [domestic partner, civil union partner], siblings, parents, children and grandparents; and
- (2) his or her spouse's [, domestic partner's, or civil union partner's] relatives of like degree.

POLICY means the Group Accident Insurance policy issued by the Company to the Group Policyholder.

SICKNESS means:

- (1) illness;
- (2) pregnancy; or
- (3) bacterial infection, except an infection which results from an Accidental injury or an infection which results from Accidental, involuntary or unintentional ingestion of a contaminated substance.

YOU and YOUR means an eligible member for whom the coverage provided by the Policy is in effect.

SPECIMEN

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:

- (1) the Policy and any amendments to it[; and]
- (2) the Group Policyholder's application[; and]
- [(3) any Participation Organization's Application or Participation Agreement.]

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons [or Insured Dependents] are representations and not warranties. No statement made by an Insured Person [or Insured Dependent] will be used to contest the insurance provided by the Policy, unless:

- (1) it is contained in a written statement signed by that Insured Person [or Insured Dependent];
and
- (2) a copy of the statement has been furnished to that Insured Person [or Insured Dependent].

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person [or Insured Dependent], after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:

- (1) the Policy's eligibility requirements, exclusions and limitations; and
- (2) other Policy provisions unrelated to the validity of insurance.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person [or Insured Dependent] were misstated:

- (1) a fair adjustment of the premium will be made; and
- (2) the true facts will decide if and in what amount insurance is valid under the Policy.

If any Insured Person's [or Insured Dependent's] age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable based upon his or her correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy, all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:

- (1) Workers' Compensation laws; or
- (2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Certificate may not be assigned.

**ELIGIBILITY AND EFFECTIVE DATES FOR
PERSONAL ACCIDENT INSURANCE**

ELIGIBILITY. A Person becomes eligible for insurance provided by the Policy on the [later/latest of]:

- (1) the Policy's date of issue[; or]
- [(2) the date a Person's organization becomes a Participating Organization][; or]
- [(3) the date the Waiting Period is completed.]

ENROLLMENT. A Person may enroll for Personal Accident Insurance only:

- (1) when first eligible; or
- (2) during any Annual/Open Enrollment Period.

EFFECTIVE DATE. Personal Accident Insurance becomes effective on the latest of:

- (1) the date you become eligible for the insurance;
- (2) the date after your final discharge from a hospital or other health care facility, if you are confined to such facility on the date you would otherwise become eligible; or
- (3) if you contribute to the cost of the Personal Accident Insurance, the date you make written application for insurance and pay the required premium to the Company.

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date on which you become eligible for the increase;
- (2) the first day of the Insurance Month coinciding with or next following your final discharge from a hospital or other health care facility, if you are confined to such facility on the date the increase would otherwise take effect; or
- (3) the day you resume the normal activities of a healthy person of the same age and sex, if you are in a Period of Limited Activity and unable to perform such activities on the date the increase would otherwise take effect.

Any reduction in insurance or benefits will take effect on the day of the change.

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Personal Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

SPECIMEN

TERMINATION OF PERSONAL ACCIDENT INSURANCE

TERMINATION. Your insurance will terminate at 12:00 midnight on the earliest of:

- (1) the date the Policy terminates [or the Participating Organization's participation terminates] (but without prejudice to any claim incurred prior to termination.);
- (2) the date your Class is no longer eligible for insurance;
- (3) the date you cease to be a member of the Eligible Class;
- (4) the last day of the Insurance Month in which you request termination;
- (5) the last day of the last Insurance Month for which premium payment is made on your behalf;
- (6) the end of the period for which the last required premium has been paid;
- (7) with respect to any particular insurance benefit, the date the portion of the Policy providing that type of benefit terminates;
- (8) the date your membership with the Group Policyholder terminates; or
- (9) the date you enter armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

PORTABILITY. If insurance under the Policy would end for any reason other than nonpayment of premiums, you have the option to continue Personal Accident Insurance and Dependent Accident Insurance. To continue insurance under this section, you must:

- (1) notify the Company within 31 days of the date the insurance would otherwise end; and
- (2) pay the applicable premium to the Company.

Portability is not available when insurance terminates solely because your spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earliest of:

- (1) the last day of the period for which you paid premiums; or
- (2) the date the Company receives a written request from you to terminate the insurance.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while you were insured under the Policy.

SPECIMEN

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT ACCIDENT INSURANCE

DEPENDENT means your:

- (1) legal spouse, who is not legally separated from you;
- (2) unmarried child less than 26 years of age; [or]
- (3) unmarried child, who is at least 26 years of age but less than 30 years of age, if the child:
 - (a) [is an Illinois resident;]
 - [(b)] served as a member of the active or reserve components of any of the branches of the U.S. Armed Forces; and
 - [(c)] received a release or discharge other than a dishonorable discharge; or
- (4) unmarried child age 26 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability; and
 - (b) chiefly dependent upon you or other care providers for lifetime care, support and supervision. Other care providers are defined as a Community Integrated Living Arrangement, group home, supervised apartment, or other licensed or certified residential service.

The child must be covered by the [Group Policyholder's/Participating Organization's] Accident plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:

- (a) within 31 days of the day insurance would otherwise end due to age; and
- (b) thereafter, when the Company requests (but not more than once every two years).

[Dependent will also include a child that you are required to provide insurance under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree, or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).]

"Child" includes:

- (1) your natural child or legally adopted child;
- (2) a child placed with you for the purpose of adoption, from the date of placement (a child in your custody pursuant to an interim court order for adoption is an adopted child, regardless of whether a final order granting adoption is ultimately issued);
- (3) a child for whom you are required by court order to provide Accident insurance;
- (4) a stepchild [or grandchild] who resides in your household; and who is chiefly dependent on you for support; and
- (5) a foster child:
 - (a) who resides in your household;
 - (b) who is chiefly dependent on you for support; and
 - (c) for whom you have assumed full parental responsibility and control.

ELIGIBILITY. You become eligible to enroll for Dependent Accident Insurance on the latest of:

- (1) the date you become eligible for Personal Accident Insurance;
- (2) the issue date of the Policy; or
- (3) the date you first acquire a Dependent.

You again become eligible to enroll for Dependent Accident Insurance under the Policy during any Annual/Open Enrollment Period.

You must be insured for Personal Accident Insurance to insure your Dependents. [Dependents to be insured by the Policy must be enrolled in the same plan of benefits as you.]

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Dependent Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

**ELIGIBILITY AND EFFECTIVE DATES FOR
DEPENDENT ACCIDENT INSURANCE
(Continued)**

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Accident Insurance will become effective on the latest of:

- | | |
|--|--|
| | (1) <u>the first day of the Insurance Month coinciding with or next following the date you become eligible for Dependent Accident Insurance; or</u> |
| | (2) <u>the first day of the Insurance Month coinciding with or next following the date you make written application for Dependent Accident Insurance; and pay the required Dependent premium to the Company.</u> |

COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires you to provide Accident benefits for the child, the insurance will become effective on the date stated in the court order; subject to payment of any additional premium.

NEW DEPENDENTS. If additional premium is required to add a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) you complete a written application; and
- (2) the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

If additional premium is not required, coverage for a new Dependent will become effective on the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically insured for the first 31 days following birth. If you elect not to enroll the newborn child and pay any additional premium within 31 days following birth, the newborn child's insurance will terminate.

SPECIMEN

TERMINATION OF DEPENDENT ACCIDENT INSURANCE

TERMINATION. Accident Insurance on a Dependent will cease on the date he or she ceases to be an eligible Dependent, as defined in the Policy.

Dependent Accident Insurance will cease for all your Insured Dependents on the earliest of:

- (1) the date your Accident Insurance terminates;
- (2) the date Dependent Accident Insurance is discontinued under the Policy;
- (3) the date you cease to be in a class eligible for Dependent Accident Insurance;
- (4) the date you request that the Dependent Accident Insurance be terminated;
- (5) with respect to a benefit or a specific type of benefit, the date the portion of the Policy providing that type of benefit terminates; or
- (6) the date through which premium has been paid on behalf of the Insured Dependents.

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while the Insured Dependent was insured under the Policy.

CONTINUATION OF DEPENDENT COVERAGE. If Dependent Accident Insurance ceases, it may be continued:

- (1) for up to two years in the case of:
 - (a) your death, divorce or legal separation; or
 - (b) a Dependent child reaching the limiting age; or
- (2) until your spouse becomes eligible for Medicare, if your spouse is age 55 or older at the time of your retirement or death, or at the time of divorce or legal separation from you.

The [Group Policyholder/Participating Organization] must be notified that the continuation is requested; this notification must be in writing and must be submitted within 30 days of the death, retirement, decree of divorce or separation, or the attainment of the limiting age. The [Group Policyholder/Participating Organization] shall provide a written notice to the Company within 15 days after receiving notice that the continuation has been requested. When the [Group Policyholder/Participating Organization] sends notice to the Company that continued coverage has been requested, the [Group Policyholder/Participating Organization] will send a copy of such notice to the Dependent at the same time.

Within 30 days after the Company receives notice of the intent to continue the coverage, the Company will send by certified mail with a return receipt requested:

- (1) a form to elect continued coverage;
- (2) the amount of periodic premiums to continue coverage and the method and place for payment; and
- (3) instructions to return the election form within 30 days after its receipt from the Company.

If the Company fails to send the election notice within 30 days, coverage will remain in force provided:

- (1) the Policy remains in force; and
- (2) Dependent Accident Insurance is provided under the Policy.

No premiums will be due until the election notice is sent.

The continuee is responsible for payment of premium at the group rate. After the Dependent Accident Insurance has been continued for two years, the payment of premium may include an administrative fee not to exceed 20 percent of the monthly premium, if your spouse was age 55 or older:

- (1) at the time of your retirement or death; or
- (2) at the time of divorce or legal separation from you.

**TERMINATION OF
DEPENDENT ACCIDENT INSURANCE
(Continued)**

Continued Dependent Accident Insurance will terminate on the earliest of:

- (1) the date the continuee becomes eligible for benefits under another group Accident plan;
- (2) the date the Policy terminates;
- (3) the date Dependent Accident Insurance is no longer provided under the Policy;
- (4) the date the spouse remarries;
- (5) the date the maximum continuation period ends;
- (6) for a Dependent child, the date that coverage would otherwise end; except for a Dependent child who has reached the limiting age, coverage may be continued for the maximum continuation period; or
- (7) the date on which coverage ceases because of a failure to make timely payment of premium; however, premium is considered timely if paid within the Grace Period.

SPECIMEN

EMERGENCY CARE BENEFITS

The Company will pay [one or more of] the following emergency care benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

AMBULANCE TRANSPORTATION. The Company will pay an Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by ground transportation to or from a Hospital or between medical facilities, for treatment of Injuries sustained as a result of a Covered Accident. The ambulance transportation must be within 90 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

AIR AMBULANCE TRANSPORTATION. The Company will pay an Air Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by air ambulance to or from a Hospital or between medical facilities for treatment of Injuries sustained as the result of a Covered Accident. The air ambulance transportation must be within 48 hours of the Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit may be paid in addition to the Ambulance Transportation benefit.

EMERGENCY CARE TREATMENT. The Company will pay an Emergency Care Treatment benefit if you [or your Insured Dependent] [are/is] examined or treated in an Emergency Care Facility as a result of a Covered Accident. The emergency care treatment must be received within 72 hours of a Covered Accident. This benefit will be paid once per person per Covered Accident.

INITIAL PHYSICIAN OFFICE VISIT. The Company will pay an Initial Physician Office Visit benefit if you [or your Insured Dependent] [are/is] examined or treated by a Physician or Medical Health Professional in an office of practice as a result of a Covered Accident. The examination or treatment must be administered within 60 days of a Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit will not be payable if you [or your Insured Dependent] receive[s] payment for the Emergency Care Treatment benefit, as described above.

MAJOR DIAGNOSTIC EXAM. The Company will pay a Major Diagnostic Exam benefit if you or an Insured Dependent undergoes one of the following major diagnostic exams as a result of a Covered Accident:

- (1) a computed tomography (CT or CAT) scan;
- (2) a magnetic resonance imaging (MRI);
- (3) a positron emission tomography (PET) scan;
- (4) an electroencephalography (EEG);
- (5) a spectroscopy (SPECT);
- (6) a joint imaging scan;
- (7) a diffusion tensor imaging (DTI) scan; or
- (8) a magnetic resonance angiogram (MRA) scan.

A major diagnostic exam must be prescribed by a Physician and performed within 60 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

TREATMENT CARE BENEFITS

The Company will pay [one or more of] the following treatment care benefit[s] if you [or your Insured Dependent] meet the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

HOSPITAL ADMISSION. The Company will pay a Hospital Admission benefit if you [or your Insured Dependent] [are/is] admitted to a Hospital as a result of a Covered Accident. The admission must occur within 180 days of a Covered Accident. The Company will not pay this benefit for emergency room treatment, Outpatient Treatment, or a stay of less than 20 hours in an Observation Unit. This benefit is payable once per person per Covered Accident.

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement benefit for each day you [or your Insured Dependent] [are/is] confined in a Hospital as the result of a Covered Accident. The initial confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 365 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accident. In the event this Hospital Confinement benefit and an Intensive Care Unit Confinement Benefit are payable on the same day, only the Intensive Care Unit Confinement benefit will be paid.

INTENSIVE CARE UNIT (ICU) CONFINEMENT. The Company will pay an ICU Confinement benefit for each day or partial day you [or your Insured Dependent] [are/is] confined in an ICU as the result of a Covered Accident. The confinement must begin within 30 days of a Covered Accident. The ICU confinement period begins on the day of admission to the ICU and ends on the day of discharge from the ICU. This benefit will be paid for up to 15 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one ICU Confinement at a time, even if it is caused by more than one Covered Accident. In the event this ICU Confinement benefit and the Hospital Confinement benefit are payable on the same day, only the ICU benefit will be paid. If you [or your Insured Dependent] exhaust[s] the ICU benefit but is still confined, you [or your Insured Dependent] may be eligible for the Hospital Confinement benefit.

ALTERNATE CARE AND REHABILITATIVE FACILITY CONFINEMENT. The Company will pay an Alternate Care or Rehabilitative Facility Confinement benefit for each day you [or your Insured Dependent] [are/is] confined on an Inpatient basis in an Alternate Care or Rehabilitative Facility as a result of a Covered Accident. The confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 90 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Alternate Care or Rehabilitative Facility Confinement at a time, even if it is caused by more than one Covered Accident. The Alternate Care and Rehabilitative Facility Confinement benefit will not be paid on any day when the Hospital or ICU Confinement benefit is paid.

FOLLOW-UP CARE. The Company will pay a Follow-Up Care benefit for each occurrence of follow-up care for Physician treatment, physical therapy, occupational therapy, or home health care that result from Injuries sustained by you [or your Insured Dependent]. Follow-up care must be received within 365 days of a Covered Accident. Follow-up care must be provided by a Physician, Medical Health Professional, Physical Therapist, Occupational Therapist or a Home Health Care Agency. This benefit is payable for up to 6 times per person per Covered Accident. This benefit is not payable while you [or your Insured Dependent] [are/is] confined in a Hospital, ICU, or an Alternate Care or Rehabilitative Facility.

TRANSPORTATION. The Company will pay a Transportation benefit when you [or your Insured Dependent] must travel more than 100 miles one way for treatment at a Hospital or other specialized freestanding treatment facility. The treatment must be prescribed by a Physician and not available locally. This benefit is payable up to three times per person per Covered Accident. This benefit is not payable when transportation is provided by ambulance or air ambulance.

TREATMENT CARE BENEFITS
(Continued)

LODGING. The Company will pay a Lodging benefit for each day a Companion accompanies you [or your Insured Dependent] who is Hospital confined more than 100 miles from your [or your Insured Dependent's] principal place of residence due to a Covered Accident. The Companion must stay in a hotel, motel or Hospital-sponsored hospitality suite. This benefit is payable for up to 30 days, within 365 days of the Covered Accident.

FAMILY CARE. The Company will pay the Family Care Benefit if:

- (1) you [or your Insured Dependent] [are/is] confined in a Hospital, ICU or Alternate Care or Rehabilitative Facility as a result of a Covered Accident; and
- (2) you have a child or children attending a Child Care Center.

This benefit is payable for each child attending a Child Care Center on any given day you [or your Insured Dependent] [are/is] confined. The child attending a Child Care Center does not need to be insured under the Policy for this benefit to be payable but must meet the definition of Child in the Eligibility and Effective Dates for Dependent Accident Insurance provision. This benefit is payable for up to 30 days, within 365 days of the Covered Accident. The Company will pay only one Family Care benefit per child.

SPECIMEN

SPECIFIC INJURIES OR TREATMENTS

The Company will pay [one or more of] the following specific injuries or treatments benefit[s] if you [or your Insured Dependent] meet the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

FRACTURE. The Company will pay a Fracture benefit when you or an Insured Dependent sustains a Fracture or Chip Fracture as a result of a Covered Accident. The Fracture or Chip Fracture must be diagnosed by a Physician within 90 days of a Covered Accident.

DISLOCATION. The Company will pay a Dislocation benefit when you or an Insured Dependent sustains a Dislocation or Partial Dislocation as a result of a Covered Accident. The Dislocation or Partial Dislocation must be diagnosed by a Physician within 90 days of a Covered Accident.

BLOOD, PLASMA, PLATELETS. The Company will pay a benefit for your [or your Insured Dependent's]:

- (1) transfusion;
- (2) administration;
- (3) cross-matching; or
- (4) typing and processing;

of blood, plasma, or platelets administered as a result of a Covered Accident, provided this is done within 90 days of such Covered Accident. This benefit is payable once per person per Covered Accident.

BURNS. The Company will pay a Burn benefit when you [or your Insured Dependent] sustain[s] a 2nd or 3rd degree burn as a result of a Covered Accident. The 2nd or 3rd degree burn must be treated by a Physician within 72 hours of a Covered Accident. If the burns meet more than one of the Burn Benefit classifications shown in the Schedule of Benefits, the Company will pay a single highest benefit amount. This benefit is payable once per person per Covered Accident.

SKIN GRAFT. The Company will pay a Skin Graft benefit when grafting of the skin is necessary for a burn that was payable under the Burn Benefit. This benefit is payable once per person per Covered Accident.

COMA. The Company will pay a Coma benefit if you [or your Insured Dependent] [have/has] been in a Coma for 15 or more days as a result of a Covered Accident. This benefit is payable once per person per Covered Accident.

CONCUSSION. The Company will pay a Concussion benefit if you [or your Insured Dependent] sustain[s] a concussion as a result of a Covered Accident. The concussion must be diagnosed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

DENTAL INJURY. The Company will pay a Dental Injury benefit if your [or your Insured Dependent's] natural teeth are damaged and:

- (1) extracted; or
- (2) repaired by placement of a crown;

by a Dentist as a result of a Covered Accident. Initial treatment must be received within 7 days of a Covered Accident. This benefit is payable for up to one crown and one extraction per person per Covered Accident, regardless of the number of teeth involved.

SPECIFIC INJURIES OR TREATMENTS
(Continued)

EYE INJURY. The Company will pay an Eye Injury benefit if you [or your Insured Dependent] injure[s] an eye (or eyes) in a Covered Accident and:

- (1) surgical repair is performed by a Physician within 90 days of a Covered Accident; or
- (2) a Physician removes an embedded foreign body from your [or your Insured Dependent's] eye, with or without anesthesia, within 90 days of a Covered Accident.

This benefit is payable once for each eye per person per Covered Accident.

JOINT REPLACEMENT. The Company will pay a Joint Replacement benefit when you [or your Insured Dependent] sustain[s] an Injury requiring a hip, knee, or shoulder joint replacement as a result of a Covered Accident. The joint replacement must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable for each required replacement per person per Covered Accident.

LACERATION. The Company will pay a Laceration benefit when you [or your Insured Dependent] sustain[s] a laceration as a result of a Covered Accident. The laceration must be treated by a Physician or Medical Health Professional within 72 hours of a Covered Accident. This benefit is payable:

- (1) once for lacerations not requiring sutures, regardless of the number; and
- (2) once for the total length of all lacerations requiring sutures;

per person as a result of any one Covered Accident.

KNEE CARTILAGE. The Company will pay a Knee Cartilage benefit when you [or your Insured Dependent] sustain[s] an Injury requiring the surgical repair or removal of torn knee cartilage as a result of a Covered Accident. The surgical repair or removal must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

TENDON/LIGAMENT/ROTATOR CUFF. The Company will pay the Tendon/Ligament/Rotator Cuff benefit when you [or your Insured Dependent] require[s] surgical repair of:

- (1) tendons;
- (2) ligaments; or
- (3) the muscles and tendons that make up the rotator cuff;

as a result of a Covered Accident. The surgical repair must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

RUPTURED DISC. The Company will pay the Ruptured Disc benefit when you [or your Insured Dependent] sustain[s] an Injury requiring surgical repair of a ruptured intervertebral disc as a result of a Covered Accident. The ruptured disc must be surgically repaired by a Physician within 90 days of a Covered Accident. This benefit is payable once per disc per person per Covered Accident.

SURGERY (ABDOMINAL OR THORACIC). The Company will pay the Surgery (Abdominal or Thoracic) benefit when you [or your Insured Dependent] undergo[es] abdominal or thoracic surgery as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

SURGERY (ARTHROSCOPIC). The Company will pay a Surgery (Arthroscopic) benefit when you [or your Insured Dependent] undergo[es] arthroscopic surgery, with no repair, as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSITIONAL CARE BENEFITS

The Company will pay [one or more of] the following transitional care benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

MEDICAL APPLIANCE ASSISTANCE. The Company will pay a benefit for Medical Appliances that are required by you [or your Insured Dependent] as a result of Injuries sustained in a Covered Accident. The Medical Appliance must be recommended by a Physician or Medical Health Professional and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the Physician or Medical Health Professional must recommend the Medical Appliance within two years of the Covered Accident. This benefit is payable once for any one Medical Appliance per person per Covered Accident.

Medical Appliance means an item that is intended by its manufacturer for use in directly substituting for a malfunctioning part of the body for assistance with mobility. Examples include crutches, wheel chairs and walkers.

PROSTHESIS. The Company will pay a benefit for functional prosthetic limbs that are required by you or an Insured Dependent as a result of Injuries sustained in a Covered Accident. The functional prosthetic limb must be prescribed by a Physician and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the prosthetic limb must be prescribed by a Physician and received within two years of the Covered Accident. This benefit is payable once per limb per person per Covered Accident.

REASONABLE MODIFICATIONS. The Company will pay a benefit for reasonable modifications made to you [or your Insured Dependent's]:

- (1) principal place of residence; or
- (2) vehicle;

provided you [or your Insured Dependent] suffered a Catastrophic Loss as described in the Schedule of Benefits. Modifications must be made within two years from the date of the Covered Accident. This benefit is payable once per person per Covered Accident.

SPECIMEN

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The Company will pay [one or more of] the following AD&D benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH OR DISMEMBERMENT. The Company will pay an Accidental Death or Dismemberment benefit when you [or your Insured Dependent] sustain[s] an Injury that causes death or dismemberment as a result of a Covered Accident. The Injury must cause death or dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss.

The Accidental Dismemberment Benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when you [or your Insured Dependent] sustain[s] a Common Carrier Accident that results in your [or your Insured Dependent's] death or dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSPORTATION OF REMAINS. The Company will pay a Transportation of Remains benefit if you [or your Insured Dependent] die[s] at least 100 miles from your [or your Insured Dependent's] principal place of residence as a result of a Covered Accident, and the bodily remains or ashes are returned:

- (1) by a company that provides mortuary transport services; and
- (2) to a mortuary or funeral home within 30 miles of the deceased's principal place of residence.

The Company will pay for only one Transportation of Remains benefit per person.

A benefit payable for the transportation of your remains will be paid in accord with the Beneficiary provision. [A benefit payable for the transportation of your Insured Dependent's remains will be paid to you.]

SEAT BELT/HELMET. If you [or your Insured Dependent]:

- (1) [were/was] wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) suffer[s] an AD&D loss;

the Accidental Death or Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

COMMON DISASTER. The Company will pay a Common Disaster benefit if both you and your Insured Dependent Spouse:

- (1) is Injured in the same Covered Accident; and
- (2) lose your lives as a direct result of such Injuries within 365 days of the Common Accident.

The Common Disaster benefit increases your Insured Dependent Spouse's benefit for Accidental loss of life to equal the your Accidental Death Benefit.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when you [or your Insured Dependent] sustain[s] an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment Benefit will not be paid for the same or attached body part.

ACCIDENTAL DISMEMBERMENT BENEFITS

The Company will pay one or more of the following accidental dismemberment benefits if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DISMEMBERMENT. The Company will pay an Accidental Dismemberment benefit when you [or your Insured Dependent] sustain[s] an Injury that causes a dismemberment as a result of a Covered Accident. The Injury must cause dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss

The Accidental Dismemberment Benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when you [or your Insured Dependent] sustain[s] a Common Carrier Accident that results in your [or your Insured Dependent's] dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

SEAT BELT/HELMET. If you [or your Insured Dependent]:

- (1) [were/was] wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) [suffer/suffers] an Accidental Dismemberment;

the Accidental Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when you [or your Insured Dependent] sustain[s] an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

SPECIMEN

LIMITATIONS AND EXCLUSIONS

The Policy covers only Injuries that occur while insurance is in force. Benefits are not payable for any loss if the loss results directly from or was in any degree caused by:

- (1) disease, physical or mental infirmity, Sickness, or medical or surgical treatment of these;
- (2) intentional self-inflicted injury or self-destruction, or any attempt thereof; suicide or suicide attempt, whether sane or insane;
- (3) deliberate use of drugs, poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, except when administered within the therapeutic levels and dosage prescribed by a licensed Physician;
- (4) participation in, commission of or attempt to commit a felony;
- (5) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind;
- (6) duty as a member of any military, including Reserves or National Guard;
- (7) travel or flight in or on any Aircraft, except:
 - (a) as a fare-paying passenger on a regularly scheduled commercial flight; [or
 - (b) as a passenger or pilot in the Group Policyholder's or Participating Organization's aircraft while flying on the Group Policyholder's or Participating Organization's business provided:
 - (i) the aircraft has a valid U.S. airworthiness certificate (or foreign equivalent); and
 - (ii) the pilot has a valid pilot's certificate with a non-student rating authorizing him to fly the aircraft];
- (8) your [or your Insured Dependent] having a blood alcohol level of 0.08 grams of alcohol or more per 100 milliliters of blood;
- [(9) injury arising out of or in the course of any employment for wage or profit];
- (10) high risk sports or extreme sports such as, but not limited to, bungee jumping, parachuting, base jumping, or mountaineering;
- (11) cosmetic or elective surgery;
- (12) being incarcerated in any type of penal or detention facility;
- (13) participating in or practicing for, or officiating, any semi-professional or professional sport;
- (14) riding in or driving in any motor driven vehicle for race, stunt show or speed test; or
- (15) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

SPECIMEN

BENEFICIARY

PAYMENTS TO BENEFICIARY. At your death, any amount payable as a result of your death will be paid to the named Beneficiary who survives you. If no named Beneficiary survives you, payment will be made to your estate or in accord with the Facility of Payment section.

PAYMENTS TO BENEFICIARY. At your death, any amount payable as a result of your death will be paid to the named Beneficiary who survives you. If you have not named a Beneficiary, or if no named Beneficiary survives you; then payment will be made to your:

- (1) surviving spouse[, domestic partner, or civil union partner]; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving sibling or siblings in equal shares; or, if none
- (5) estate.

If determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

- (1) within 15 days of your death; and
- (2) before the Company receives satisfactory proof of your death;

payment will be made as if you had survived that person, unless other provisions have been made.

NAMING THE BENEFICIARY. Your Beneficiary will be as shown on your enrollment form, unless changed. If the Policy replaces a group policy providing similar coverages; then your beneficiary named under the prior policy will be the beneficiary under the Policy, until changed.

CHANGING THE BENEFICIARY. Only you or your assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change [with the Company at its Group Insurance Service Office/Group Policyholder] prior to your death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under the Policy becomes payable to your estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

- (1) a person who has assumed the care and support of you or a Beneficiary;
- (2) a person who has incurred expense as a result of your last illness or death;
- (3) the personal representative of your estate; or
- (4) any person related by blood or marriage to you.

No payment made to anyone named above may exceed \$1,000. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) your name, address and certificate number, if available; and
- (3) the patient's name and relationship to you.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then you may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of services; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

- (1) the nature, date and cause of the claim;
- (2) a description of the services provided; and
- (3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

- (1) any study models, treatment records or charts;
- (2) copies of any x-rays or other diagnostic materials; and
- (3) any other items the Company may reasonably require.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While an Accident claim is pending, the Company may have the claimant examined:

- (1) by a Physician of its choice;
- (2) as often as is reasonably required.

Any such exam will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Accident Benefits payable under this Certificate will be paid immediately after the Company receives complete proof of claim that is acceptable to the Company and confirms liability.

If a claim is not paid or properly denied within 30 days after the Company receives complete and acceptable proof of claim; then any overdue benefit payment will accrue interest, at a rate of 9% per annum, until the claim is paid.

TO WHOM PAYABLE

Accidental Death & Dismemberment. Benefits due to loss of your life will be paid in accord with the Beneficiary provision. All other benefits will be paid to you.

[Other] Accident Benefits. Any [other] Accident Benefits will be paid to you; unless[:]

- [(1)] an overpayment has been made and the Company is entitled to reduce future benefits; or
- [(2)] state or federal law requires that benefits be paid to an Insured Dependent child's custodial parent or custodian.]

CLAIM PROCEDURES FOR ACCIDENT INSURANCE
(Continued)

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within 90 days after receiving the first proof of [a death] [or other/an] Accident claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case, then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within 180 days after receiving the first proof of [a death] [or other/an] Accident claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of [a death] [or other/an] Accident claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, then the notice will also describe:

- (1) any further appeal procedures available under the Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

For [a death] [or other/an] Accident claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal, then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE
(Continued)

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) the claimant's receipt of benefits or services under another plan;
- (3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

SPECIMEN

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL000000000000 has been issued to
American Benefits Association
(The Group Policyholder)

The Issue Date of the Policy is Month Day, Year.

Participating Organization: XYZ Company

Participating Organization's Effective Date: _____

Certificate of Insurance for [for Plan 1/ Class 1]

[Insured Person's Name]
[Insured Person's Effective Date]
[Certificate Number]

SPECIMEN

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. [If you have elected Dependent coverage on your enrollment form, your Dependents are covered under this Certificate only if such Dependents are eligible for insurance under the Policy and the required premium has been paid.] This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.


President

READ YOUR CERTIFICATE CAREFULLY

**This is a limited benefit certificate. It provides accident only insurance coverage.
There is no coverage for hospital, medical-surgical or major medical expenses.**

This certificate is subject to the laws of the State of New Jersey.

CERTIFICATE OF GROUP ACCIDENT INSURANCE

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SPECIMEN

[ABC Company, Incorporated]
[000000000000]

SCHEDULE OF BENEFITS

[For Plan 1/ Class 1]

ELIGIBLE CLASS means: All Full-Time Employees who are members in good standing with the Group Policyholder

[ANNUAL/OPEN ENROLLMENT PERIOD: November 15 – December 14]

ELIGIBILITY WAITING PERIOD (For date insurance begins, refer to "Effective Dates" section.)
30 days

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

EMERGENCY CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Ambulance Transportation	[\$50-500]
Air Ambulance Transportation	[\$200-2,500]
Emergency Care Treatment	[\$10-400]
Initial Physician Office Visit	[\$10-200]
Major Diagnostic Exam	[\$50 - 1,500]

TREATMENT CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Hospital Admission	[\$100-3,000]
Hospital Confinement	[\$50-1,000]
Intensive Care Unit (ICU) Confinement	[\$50-1,000]
Alternate Care and Rehabilitative Facility Confinement	[\$40-1,000]
Follow-up Care	[\$10-100]
Transportation	[\$50-900]
Lodging	[\$50-350]
Family Care	[\$10 - 200]

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS

Type of Injury/Treatment

Benefit Amount

Fractures

Non Surgical

Surgical

Ankle	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Arm (shoulder to elbow)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Arm (elbow to wrist)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Bones of Face (except those listed below)	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Coccyx	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Collarbone	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Elbow	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Finger	[<u>\$10-2,000</u>]	[<u>\$10-2,000</u>]
Foot (except toes)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Hand (except fingers)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Hip	[<u>\$100-8,000</u>]	[<u>\$100-8,000</u>]
Kneecap	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Leg (hip to knee)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Leg (knee to ankle)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Lower Jaw	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Nose	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Pelvis	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Rib	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Shoulder blade	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Skull (depressed)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Skull (non-depressed)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Sternum	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Toe	[<u>\$10-2,000</u>]	[<u>\$10-2,000</u>]
Upper Jaw	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Vertebrae	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Vertebral Column	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Wrist	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]

Chip Fracture	[<u>10-50% of the amount payable for full fracture</u>]
Multiple Fractures	[<u>Highest amount of 2 – 10 fractures sustained</u>]

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>	
	<u>Non-Surgical</u>	<u>Surgical</u>
Dislocations		
Ankle	[\$50-5,000]	[\$50-5,000]
Collarbone (sternoclavicular)	[\$50-5,000]	[\$50-5,000]
Collarbone (acromio and separation)	[\$50-3,000]	[\$50-3,000]
Elbow	[\$50-3,000]	[\$50-3,000]
Finger	[\$10-2,000]	[\$10-2,000]
Foot (except toes)	[\$50-5,000]	[\$50-5,000]
Hand (except fingers)	[\$50-5,000]	[\$50-5,000]
Hip	[\$100-12,000]	[\$100-12,000]
Knee (not kneecap)	[\$50-5,000]	[\$50-5,000]
Lower Jaw	[\$50-5,000]	[\$50-5,000]
Shoulder	[\$50-5,000]	[\$50-5,000]
Toe	[\$10-2,000]	[\$10-2,000]
Wrist	[\$50-5,000]	[\$50-5,000]
Partial Dislocation	[10-50% of benefit payable for Dislocation]	
Multiple Dislocations	[Highest amount of 2 - 10 dislocations sustained]	
Combination of Dislocation(s) and Fracture(s)	[Highest amount of 2 - 10 dislocations or fractures sustained]	
Transfusions: Blood, Plasma, Platelets	[\$25-900]	
Burns		
<u>2nd Degree</u>		
< 9%	[\$100-800]	
10-18%	[\$100-2,500]	
19-36%	[\$200-5,000]	
37% +	[\$300-8,000]	
<u>3rd Degree</u>		
< 9%	[\$300-8,000]	
10-18%	[\$500-13,000]	
19-36%	[\$800-25,000]	
37% +	[\$1,000-50,000]	
Skin Grafts (due to burns)	[10-50% of benefit payable for Burns]	

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>
Coma	<u>[\$200-15,000]</u>
Concussion	<u>[\$10-500]</u>
Dental Injury - Emergency Dental Work for the following:	
Crown	<u>[\$10-500]</u>
Extraction	<u>[\$10-300]</u>
Eye Injury	
Surgical repair	<u>[\$20-900]</u>
Removal of foreign body	<u>[\$20-700]</u>
Joint Replacement	
Hip	<u>[\$500-15,000]</u>
Knee	<u>[\$500-15,000]</u>
Shoulder	<u>[\$500-15,000]</u>
Lacerations	
No Sutures Required	<u>[\$5-500]</u>
Sutures Required (Total Length of all Sutures/Lacerations)	
up to 5cm:	<u>[\$10-800]</u>
5.1-15.5cm:	<u>[\$25-2,000]</u>
15.6cm+:	<u>[\$50-3,000]</u>
Knee Cartilage	<u>[\$50-2,500 per repair]</u>
Ligaments/Tendons/Rotator Cuff	<u>[\$50-2,500 per repair]</u>
Ruptured Disc	<u>[\$50-2,500]</u>
Surgery – Abdominal or Thoracic	<u>[\$100-3,000]</u>
Surgery – Arthroscopic	<u>[\$100-800]</u>

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

TRANSITIONAL CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Medical Appliance Assistance	
Crutches	[\$10-100]
Wheelchair – expected use less than 1 year	[\$50-250]
Wheelchair – expected use 1 year or longer	[\$200-2,000]
Walker – expected use less than 1 year	[\$10-100]
Walker – expected use 1 year or longer	[\$50-250]
Other Medical Appliance used for mobility	[\$10-100]
Prosthesis	[\$200-5,000 per device]
Reasonable Modifications	[\$500-15,000]

SPECIMEN

**SCHEDULE OF BENEFITS
(Continued)**

ACCIDENTAL [DEATH and] DISMEMBERMENT BENEFITS [AD&D]

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Loss	
Loss of Life	[\$5,000-200,000]
Loss of Hand, Foot, Arm, Leg, Eye, or Hearing in One Ear	[\$2,000-40,000]
Any Loss of finger, thumb, or toe	[\$50-2,500]
Common Carrier Accident	[1-2 times AD&D Benefit Amount/\$10,000-300,000]
Common Disaster	[1.5-3 times AD&D Benefit Amount]
Transportation of Remains	[\$3,000-20,000]
Seat Belt/Helmet	[5-15% of AD&D Benefit Amount]
Catastrophic Loss	[\$5,000-150,000]
Loss of Sight in Both Eyes	
Loss of Hearing in Both Ears	
Loss of Speech	
Loss of Both Arms and Both Legs	
Loss of Both Arms	
Loss of Both Legs	
Loss of Arm and Leg	

SPECIMEN

DEFINITIONS

ACCIDENT or **ACCIDENTAL** refers to an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

ACTIVE WORK or **ACTIVELY AT WORK** means a member of the Group Policyholder who is engaged in employment on a full-time basis for the Minimum Hours shown in the Schedule of Insurance and performing all customary duties of his or her occupation.

Unless disabled on the prior workday or on the day of absence, a member will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday; or
- (2) a paid vacation day, or other scheduled or unscheduled non-workday.

AIRCRAFT means any device used for aerial navigation, including but not limited to, airplanes, helicopters, balloons, gliders, parachutes, hang gliders and parasails.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible members to purchase or make changes to their Personal or Dependent Accident Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period.

CHIP FRACTURE means a fracture in which a piece of the bone is broken off.

CHILD CARE CENTER means any facility which:

- (1) is licensed as such by the state;
- (2) provides non-medical care and supervision for children in a group setting; and
- (3) is not operated by the Insured Person or a member of the Insured Person's immediate family.

COMA means a state of complete mental unresponsiveness, due to Injury, with no evidence of appropriate responses to stimulation, as diagnosed by a Physician.

COMMON CARRIER means any land, air or water conveyance operated under a license to transport passengers for hire.

COMMON CARRIER ACCIDENT means a Covered Accident while the Insured Person [or Insured Dependent] is a fare-paying passenger on a Common Carrier.

COMPANION means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

COVERED ACCIDENT means an Accident that:

- (1) occurs while the Insured Person's [or Insured Dependent's] coverage under the Policy is in effect;
- (2) results in an Injury; and
- (3) is not otherwise excluded under the terms of the Policy.

**DEFINITIONS
(Continued)**

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the [Group Policyholder's/Participating Organization's] place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

DEPENDENT ACCIDENT INSURANCE means the coverage provided by the Policy for eligible Dependents.

DISLOCATION means a completely separated joint. A Partial Dislocation means that the joint is misaligned, but not completely dislocated, as diagnosed by a Physician.

ELIGIBILITY WAITING PERIOD means the period of time a member is in good standing with the [Group Policyholder/Participating Organization], before he or she becomes eligible to enroll for insurance under the Policy.

EMERGENCY CARE FACILITY means an emergency room or urgent care facility recognized by the laws of the state where located.

FRACTURE means a broken bone that can be determined by a diagnostic exam.

FULL-TIME EMPLOYEE means a person:

- (1) who is regularly scheduled to work at least the Minimum Hours shown in the Schedule of Insurance per week;
- (2) who is a member of an eligible class under the Policy; and
- (3) who is a citizen of the United States or legally works in the United States.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of the Policy.

HOME HEALTH CARE AGENCY means an agency that provides skilled nursing and other home health care services according to state and/or local laws on a visiting basis in the Insured Person's temporary or principal place of residence.

HOSPITAL means a general hospital which:

- (1) is licensed, approved or certified by the state where it is located;
- (2) is recognized by the Joint Commission;
- (3) is operated to treat Inpatients;
- (4) has a registered nurse always on duty; and
- (5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:

- (1) is specialized solely in dentistry, mental illness or substance abuse;
- (2) is a rest home, home for the aged, convalescent home or nursing home; or
- (3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

HOSPITAL CONFINEMENT means being a registered bed patient in a Hospital upon a Physician's recommendation. Such confinement must be medically necessary to diagnose or treat a covered Injury.

INPATIENT means an Insured Person [or Insured Dependent] who is an overnight resident patient.

**DEFINITIONS
(Continued)**

INSURANCE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
 - (2) ending at 12:00 midnight on the last day of the same calendar month;
- at the [Group Policyholder's/Participating Organization's] primary place of business.

INSURED DEPENDENT means a Dependent for whom Policy coverage is in effect.

INSURED PERSON means a Person for whom Policy coverage is in effect.

INJURY OR INJURIES means bodily injury solely due to an Accident. It includes all complications of and all injuries received from the same Covered Accident.

INTENSIVE CARE UNIT (ICU) means a designated part of a Hospital that:

- (1) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
- (3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- (4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
- (5) is assigned a Physician on a full-time basis.

LOSS, as used in the Dismemberment and Catastrophic Loss Benefits, means coverage or loss of function:

- (1) of the hand through or above the wrist joint;
- (2) of the foot through or above the ankle joint;
- (3) of the arm above the elbow;
- (4) of the leg above the knee;
- (5) of sight in an eye, total and permanent loss of sight;
- (6) of hearing, deafness in an ear that cannot be corrected to any functional degree by any procedure, aid or device;
- (7) of speech, the loss of audible communication such that it cannot be corrected to any functional degree by any procedure, aid or device;
- (8) of a finger or a thumb; or
- (9) of a toe.

Loss of function means the total and irrevocable loss of use.

MEDICAL HEALTH PROFESSIONAL means a person, other than a Physician, that renders medical care and performs services that are within the scope of such person's license. Included in this definition are registered nurses, physician's assistants, and nurse practitioners.

OBSERVATION UNIT means a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician and which:

- (1) is under the direct supervision of a Physician or registered nurse;
- (2) is staffed by nurses assigned specifically to that unit; and
- (3) provides care seven days per week, 24 hours per day.

OCCUPATIONAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice occupational therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Occupational Therapy Association.

**DEFINITIONS
(Continued)**

OUTPATIENT TREATMENT means medical services that an Insured Person [or Insured Dependent] receives when not confined as an Inpatient in a Hospital.

PERSON means a Full-Time Employee who is a member in good standing with the Group Policyholder[:]
[(1) who is a member of a class that is eligible for insurance under the Policy[; and]
[(2) who has completed an enrollment form].

PERSONAL ACCIDENT INSURANCE means the insurance provided by the Policy for Insured Persons.

PHYSICAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice physical therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Physical Therapy Association.

PHYSICIAN means:

- (1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
- (2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:

- (1) the Insured Person's spouse, [domestic partner, civil union partner], siblings, parents, children and grandparents; and
- (2) his or her spouse's [, domestic partner's or civil union partner's] relatives of like degree.

POLICY means the Group Accident Insurance policy issued by the Company to the Group Policyholder.

SICKNESS means:

- (1) illness;
- (2) pregnancy; or
- (3) infection, except when the infection is due to an Accidental cut or wound.

TERRORISM means activities against persons, organizations or property of any nature if such activities involve the following or preparation for the following:

- (1) use or threat of force or violence;
- (2) commission or threat of a dangerous act; or
- (3) commission or threat of an act that interferes with or disrupts an electronic, communication, information or mechanical system; and

when one or both of the following applies:

- (1) the effect is to intimidate or coerce a government or the civilian population or any segment thereof, or to disrupt any segment of the economy; or
- (2) it appears that the intent is to intimidate or coerce a government, or to further political, ideological, religious, social or economic objectives or to express (or to express opposition to) a philosophy or ideology.

YOU and YOUR means an eligible Employee for whom the coverage provided by the Policy is in effect.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:

- (1) the Policy and any amendments to it[; and]
- (2) the Group Policyholder's application[; and]
- [(3) any Participation Organization's Application or Participation Agreement.]

All statements made by the Group Policyholder and by Insured Persons [or Insured Dependents] are representations and not warranties. No statement made by an Insured Person [or Insured Dependent] will be used to contest the insurance provided by the Policy, unless:

- (1) it is contained in a written statement signed by that Insured Person [or Insured Dependent];
and
- (2) a copy of the statement has been furnished to that Insured Person [or Insured Dependent].

INCONTESTABILITY. Except for the non-payment of premiums, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person [or Insured Dependent], after his or her insurance has been in force for two years during his or her lifetime. During such two-year period, the Company may contest the validity as to the Insured Person [or Insured Dependent] on the basis of the Insured Person's [or Insured Dependent's] signed, written statement relating to his or her own insurability. This clause does not preclude, at any time, the assertion of defenses based upon:

- (1) the Policy's eligibility requirements, exclusions and limitations; and
- (2) other Policy provisions unrelated to the validity of insurance.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person [or Insured Dependent] were misstated:

- (1) a fair adjustment of the premium will be made, and
- (2) the true facts will decide if and in what amount insurance is valid under the Policy.

If any Insured Person's [or Insured Dependents] age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:

- (1) Workers' Compensation laws; or
- (2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Certificate may not be assigned.

**ELIGIBILITY AND EFFECTIVE DATES FOR
PERSONAL ACCIDENT INSURANCE**

ELIGIBILITY. A Person becomes eligible for insurance provided by the Policy on the [later/latest of]:

- (1) the Policy's date of issue[; or]
- [(2) the date a Person's organization becomes a Participating Organization][; or]
- [(3) the date the Waiting Period is completed.]

ENROLLMENT. A Person may enroll for Personal Accident Insurance only:

- (1) when first eligible; or
- (2) during any Annual/Open Enrollment Period.

EFFECTIVE DATE. Personal Accident Insurance becomes effective on the latest of:

- (1) the date you become eligible for the insurance;
- (2) the date you resume Active Work, if not Actively at Work on the day your insurance would otherwise take effect; or
- (3) if you contribute to the cost of the Personal Accident Insurance, the date you make written application for insurance and pay the required premium to the Company.

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date on which you become eligible for the increase, if Actively at Work on that day; or
- (2) the day you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any reduction in insurance or benefits will take effect on the day of the change, whether or not you are Actively at Work.

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Personal Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

SPECIMEN

TERMINATION OF PERSONAL ACCIDENT INSURANCE

TERMINATION. Your insurance will terminate at 12:00 midnight on the earliest of:

- (1) the date the Policy terminates [or the Participating Organization's participation terminates] (but without prejudice to any claim incurred prior to termination.);
- (2) the date your Class is no longer eligible for insurance;
- (3) the date you cease to be a member of the Eligible Class;
- (4) the last day of the Insurance Month in which you request termination;
- (5) the last day of the last Insurance Month for which premium payment is made on your behalf;
- (6) the end of the period for which the last required premium has been paid;
- (7) with respect to any particular insurance benefit, the date the portion of the Policy providing that type of benefit terminates;
- (8) the date your membership with the Group Policyholder or Participating Organization terminates; or
- (9) the date you enter armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.).

PORTABILITY. If insurance under the Policy would end for any reason other than nonpayment of premiums, you have the option to continue Personal Accident Insurance and Dependent Accident Insurance. To continue insurance under this section, you must:

- (1) notify the Company within 31 days of the date the insurance would otherwise end; and
- (2) pay the applicable premium to the Company.

Portability is not available when insurance terminates solely because your spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earlier of:

- (1) the last day of the period for which you paid premiums; or
- (2) the date the Company receives a written request from you to terminate the insurance.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while you were insured under the Policy.

EXTENDED PERSONAL ACCIDENT INSURANCE BENEFITS. Extended Personal Accident Insurance Benefits will be paid if, on the date the Policy terminates, you are totally disabled due to a Covered Accident. In that event, the Company will continue to pay benefits as if your insurance remained in force. Benefits will be paid until the earlier of:

- (1) 90 days from the date the Policy terminates; or
- (2) the date you are no longer totally disabled.

**ELIGIBILITY AND EFFECTIVE DATES FOR
DEPENDENT ACCIDENT INSURANCE**

DEPENDENT means your:

- (1) legal spouse or civil union partner, who is not legally separated from you;
- (2) unmarried child less than 19 years of age; [or]
- [(3) unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or]
- (4) unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability;
and
 - (b) chiefly dependent upon you for support and maintenance.The child must be covered by the [Group Policyholder's/Participating Organization's] Accident plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:
 - (a) within 31 days of the day insurance would otherwise end due to age; and
 - (b) thereafter, when the Company requests (but not more than once every two years).

[Dependent will also include a child that you are required to provide insurance under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).]

"Child" includes:

- (1) your natural child or legally adopted child;
- (2) a child placed with you for the purpose of adoption from the date of placement;
- (3) a child for whom you are required by court order to provide accident insurance;
- (4) a stepchild[,] [or] civil union partner's child[,] [or] grandchild who resides in your household; and who is chiefly dependent on you for support; and
- (5) a foster child:
 - (a) who resides in your household;
 - (b) who is chiefly dependent on you for support; and
 - (c) for whom you have assumed full parental responsibility and control.

ELIGIBILITY. You become eligible to enroll for Dependent Accident Insurance on the latest of:

- (1) the date you become eligible for Personal Accident Insurance;
- (2) the issue date of the Policy; or
- (3) the date you first acquire a Dependent.

You again become eligible to enroll for Dependent Accident Insurance under the Policy during any Annual/Open Enrollment Period.

You must be insured for Personal Accident Insurance to insure your Dependents. [Dependents to be insured by the Policy must be enrolled in the same plan of benefits as you.]

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Dependent Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

**ELIGIBILITY AND EFFECTIVE DATES FOR
DEPENDENT ACCIDENT INSURANCE
(Continued)**

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Accident Insurance will become effective on the latest of:

- | | |
|--|--|
| | (1) <u>the first day of the Insurance Month coinciding with or next following the date you become eligible for Dependent Accident Insurance; or</u> |
| | (2) <u>the first day of the Insurance Month coinciding with or next following the date you make written application for Dependent Accident Insurance; and pay the required Dependent premium to the Company.</u> |

COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires you to provide Accident benefits for the child, the insurance will become effective on the date stated in the court order; subject to payment of any additional premium.

NEW DEPENDENTS. If additional premium is required to add a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) you complete a written application; and
- (2) the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

If additional premium is not required, coverage for a new Dependent will become effective on the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically insured for the first 31 days following birth. If you elect not to enroll the newborn child and pay any additional premium within 31 days following birth, the newborn child's insurance will terminate.

SPECIMEN

**TERMINATION OF
DEPENDENT ACCIDENT INSURANCE**

TERMINATION. Accident Insurance on a Dependent will cease on the date he or she ceases to be an eligible Dependent, as defined in the Policy.

Dependent Accident Insurance will cease for all your Insured Dependents on the earliest of:

- (1) the date your Accident Insurance terminates;
- (2) the date Dependent Accident Insurance is discontinued under the Policy;
- (3) the date you cease to be in a class eligible for Dependent Accident Insurance;
- (4) the date you request that the Dependent Accident Insurance be terminated;
- (5) with respect to a benefit or a specific type of benefit, the date the portion of the Policy providing that type of benefit terminates; or
- (6) the date through which premium has been paid on behalf of the Insured Dependents.

SURVIVING DEPENDENTS. If Personal Accident Insurance terminates due to your death, Dependent Accident Insurance may be continued:

- (1) for three Insurance Months; or any longer period, if required by state or federal law;
- (2) provided the [Group Policyholder/Participating Organization] submits the premium on behalf of the surviving Dependents; and the Policy remains in force.

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while the Insured Dependent was insured under the Policy.

EXTENDED DEPENDENT ACCIDENT INSURANCE BENEFITS. Extended Dependent Accident Insurance Benefits will be paid if, on the date the Policy terminates, your Dependent is totally disabled due to a Covered Accident. In that event, the Company will continue to pay benefits as if that Dependent's insurance remained in force. Benefits will be paid until the earlier of:

- (1) 90 days from the date the Policy terminates; or
- (2) the date your Dependent is no longer totally disabled.

SPECIMEN

EMERGENCY CARE BENEFITS

The Company will pay [one or more of] the following emergency care benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

AMBULANCE TRANSPORTATION. The Company will pay an Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by ground transportation to or from a Hospital or between medical facilities, for treatment of Injuries sustained as a result of a Covered Accident. The ambulance transportation must be within 90 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

AIR AMBULANCE TRANSPORTATION. The Company will pay an Air Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by air ambulance to or from a Hospital or between medical facilities for treatment of Injuries sustained as the result of a Covered Accident. The air ambulance transportation must be within 48 hours of the Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit may be paid in addition to the Ambulance Transportation benefit.

EMERGENCY CARE TREATMENT. The Company will pay an Emergency Care Treatment benefit if you [or your Insured Dependent] [are/is] examined or treated in an Emergency Care Facility as a result of a Covered Accident. The emergency care treatment must be received within 72 hours of a Covered Accident. This benefit will be paid once per person per Covered Accident.

INITIAL PHYSICIAN OFFICE VISIT. The Company will pay an Initial Physician Office Visit benefit if you [or your Insured Dependent] [are/is] examined or treated by a Physician or Medical Health Professional in an office of practice as a result of a Covered Accident. The examination or treatment must be administered within 60 days of a Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit will not be payable if you [or your Insured Dependent] receive[s] payment for the Emergency Care Treatment benefit, as described above.

MAJOR DIAGNOSTIC EXAM. The Company will pay a Major Diagnostic Exam benefit if you or an Insured Dependent undergoes one of the following major diagnostic exams as a result of a Covered Accident:

- (1) a computed tomography (CT or CAT) scan;
- (2) a magnetic resonance imaging (MRI);
- (3) a positron emission tomography (PET) scan;
- (4) an electroencephalography (EEG);
- (5) a spectroscopy (SPECT);
- (6) a joint imaging scan;
- (7) a diffusion tensor imaging (DTI) scan; or
- (8) a magnetic resonance angiogram (MRA) scan.

A major diagnostic exam must be prescribed by a Physician and performed within 60 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

TREATMENT CARE BENEFITS

The Company will pay [one or more of] the following treatment care benefit[s] if you [or your Insured Dependent] meet the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

HOSPITAL ADMISSION. The Company will pay a Hospital Admission benefit if you [or your Insured Dependent] [are/is] admitted to a Hospital as a result of a Covered Accident. The admission must occur within 180 days of a Covered Accident. The Company will not pay this benefit for emergency room treatment, Outpatient Treatment, or a stay of less than 20 hours in an Observation Unit. This benefit is payable once per person per Covered Accident.

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement benefit for each day you [or your Insured Dependent] [are/is] confined in a Hospital as the result of a Covered Accident. The initial confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 365 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accident. In the event this Hospital Confinement benefit and an Intensive Care Unit Confinement Benefit are payable on the same day, only the Intensive Care Unit Confinement benefit will be paid.

INTENSIVE CARE UNIT (ICU) CONFINEMENT. The Company will pay an ICU Confinement benefit for each day or partial day you [or your Insured Dependent] [are/is] confined in an ICU as the result of a Covered Accident. The confinement must begin within 30 days of a Covered Accident. The ICU confinement period begins on the day of admission to the ICU and ends on the day of discharge from the ICU. This benefit will be paid for up to 15 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one ICU Confinement at a time, even if it is caused by more than one Covered Accident. In the event this ICU Confinement benefit and the Hospital Confinement benefit are payable on the same day, only the ICU benefit will be paid. If you [or your Insured Dependent] exhaust[s] the ICU benefit but is still confined, you [or your Insured Dependent] may be eligible for the Hospital Confinement benefit.

ALTERNATE CARE AND REHABILITATIVE FACILITY CONFINEMENT. The Company will pay an Alternate Care and Rehabilitative Facility Confinement benefit for each day you [or your Insured Dependent] [are/is] confined on an Inpatient basis in an Alternate Care or Rehabilitative Facility as a result of a Covered Accident. The confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 90 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Alternate Care or Rehabilitative Facility Confinement at a time, even if it is caused by more than one Covered Accident. The Alternate Care and Rehabilitative Facility Confinement benefit will not be paid on any day when the Hospital or ICU Confinement benefit is paid.

FOLLOW-UP CARE. The Company will pay a Follow-Up Care benefit for each occurrence of follow-up care for Physician treatment, physical therapy, occupational therapy, or home health care that result from Injuries sustained by you [or your Insured Dependent]. Follow-up care must be received within 365 days of a Covered Accident. Follow-up care must be provided by a Physician, Medical Health Professional, Physical Therapist, Occupational Therapist or a Home Health Care Agency. This benefit is payable for up to 6 times per person per Covered Accident. This benefit is not payable while you [or your Insured Dependent] [are/is] confined in a Hospital, ICU, or an Alternate Care or Rehabilitative Facility.

TRANSPORTATION. The Company will pay a Transportation benefit when you [or your Insured Dependent] must travel more than 100 miles one way for treatment at a Hospital or other specialized freestanding treatment facility. The treatment must be prescribed by a Physician and not available locally. This benefit is payable up to three times per person per Covered Accident. This benefit is not payable when transportation is provided by ambulance or air ambulance.

TREATMENT CARE BENEFITS
(Continued)

LODGING. The Company will pay a Lodging benefit for each day a Companion accompanies you [or your Insured Dependent] who is Hospital confined more than 100 miles from your [or your Insured Dependent's] principal place of residence due to a Covered Accident. The Companion must stay in a hotel, motel or Hospital-sponsored hospitality suite. This benefit is payable for up to 30 days, within 365 days of the Covered Accident.

FAMILY CARE. The Company will pay the Family Care Benefit if:

- (1) you [or your Insured Dependent] [are/is] confined in a Hospital, ICU or Alternate Care or Rehabilitative Facility as a result of a Covered Accident; and
- (2) you have a child or children attending a Child Care Center.

This benefit is payable for each child attending a Child Care Center on any given day you [or your Insured Dependent] [are/is] confined. The child attending a Child Care Center does not need to be insured under the Policy for this benefit to be payable but must meet the definition of Child in the Eligibility and Effective Dates for Dependent Accident Insurance provision. This benefit is payable for up to 30 days, within 365 days of the Covered Accident. The Company will pay only one Family Care benefit per child.

SPECIMEN

SPECIFIC INJURIES OR TREATMENTS

The Company will pay [one or more of] the following specific injuries or treatments benefit[s] if you [or your Insured Dependent] meet the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

FRACTURE. The Company will pay a Fracture benefit when you or an Insured Dependent sustains a Fracture or Chip Fracture as a result of a Covered Accident. The Fracture or Chip Fracture must be diagnosed by a Physician within 90 days of a Covered Accident.

DISLOCATION. The Company will pay a Dislocation benefit when you or an Insured Dependent sustains a Dislocation or Partial Dislocation as a result of a Covered Accident. The Dislocation or Partial Dislocation must be diagnosed by a Physician within 90 days of a Covered Accident.

BLOOD, PLASMA, PLATELETS. The Company will pay a benefit for your [or your Insured Dependent's]:

- (1) transfusion;
- (2) administration;
- (3) cross-matching; or
- (4) typing and processing;

of blood, plasma, or platelets administered as a result of a Covered Accident, provided this is done within 90 days of such Covered Accident. This benefit is payable once per person per Covered Accident.

BURNS. The Company will pay a Burn benefit when you [or your Insured Dependent] sustain[s] a 2nd or 3rd degree burn as a result of a Covered Accident. The 2nd or 3rd degree burn must be treated by a Physician within 72 hours of a Covered Accident. If the burns meet more than one of the Burn Benefit classifications shown in the Schedule of Benefits, the Company will pay the single highest benefit amount. This benefit is payable once per person per Covered Accident.

SKIN GRAFT. The Company will pay a Skin Graft benefit when grafting of the skin is necessary for a burn that was payable under the Burn Benefit. This benefit is payable once per person per Covered Accident.

COMA. The Company will pay a Coma benefit if you [or your Insured Dependent] [have/has] been in a Coma for 15 or more days as a result of a Covered Accident. This benefit is payable once per person per Covered Accident.

CONCUSSION. The Company will pay a Concussion benefit if you [or your Insured Dependent] sustain[s] a concussion as a result of a Covered Accident. The concussion must be diagnosed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

DENTAL INJURY. The Company will pay a Dental Injury benefit if your [or your Insured Dependent's] natural teeth are damaged and:

- (1) extracted; or
- (2) repaired by placement of a crown;

by a Dentist as a result of a Covered Accident. Initial treatment must be received within 7 days of a Covered Accident. This benefit is payable for up to one crown and one extraction per person per Covered Accident, regardless of the number of teeth involved.

SPECIFIC INJURIES OR TREATMENTS
(Continued)

EYE INJURY. The Company will pay an Eye Injury benefit if you [or your Insured Dependent] injure[s] an eye (or eyes) in a Covered Accident and:

- (1) surgical repair is performed by a Physician within 90 days of a Covered Accident; or
- (2) a Physician removes an embedded foreign body from your [or your Insured Dependent's] eye, with or without anesthesia, within 90 days of a Covered Accident.

This benefit is payable once for each eye per person per Covered Accident.

JOINT REPLACEMENT. The Company will pay a Joint Replacement benefit when you [or your Insured Dependent] sustain[s] an Injury requiring a hip, knee, or shoulder joint replacement as a result of a Covered Accident. The joint replacement must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable for each required replacement per person per Covered Accident.

LACERATION. The Company will pay a Laceration benefit when you [or your Insured Dependent] sustain[s] a laceration as a result of a Covered Accident. The laceration must be treated by a Physician or Medical Health Professional within 72 hours of a Covered Accident. This benefit is payable:

- (1) once for lacerations not requiring sutures, regardless of the number; and
- (2) once for the total length of all lacerations requiring sutures;

per person as a result of any one Covered Accident.

KNEE CARTILAGE. The Company will pay a Knee Cartilage benefit when you [or your Insured Dependent] sustain[s] an Injury requiring the surgical repair or removal of torn knee cartilage as a result of a Covered Accident. The surgical repair or removal must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

TENDON/LIGAMENT/ROTATOR CUFF. The Company will pay the Tendon/Ligament/Rotator Cuff benefit when you [or your Insured Dependent] require[s] surgical repair of:

- (1) tendons;
- (2) ligaments; or
- (3) the muscles or tendons that make up the rotator cuff;

as a result of a Covered Accident. The surgical repair must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

RUPTURED DISC. The Company will pay the Ruptured Disc benefit when you [or your Insured Dependent] sustain[s] an Injury requiring surgical repair of a ruptured intervertebral disc as a result of a Covered Accident. The ruptured disc must be surgically repaired by a Physician within 90 days of a Covered Accident. This benefit is payable once per disc per person per Covered Accident.

SURGERY (ABDOMINAL OR THORACIC). The Company will pay the Surgery (Abdominal or Thoracic) benefit when you [or your Insured Dependent] undergo[es] abdominal or thoracic surgery as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

SURGERY (ARTHROSCOPIC). The Company will pay a Surgery (Arthroscopic) benefit when you [or your Insured Dependent] undergo[es] arthroscopic surgery, with no repair, as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSITIONAL CARE BENEFITS

The Company will pay [one or more of] the following transitional care benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

MEDICAL APPLIANCE ASSISTANCE. The Company will pay a benefit for Medical Appliances that are required by you [or your Insured Dependent] as a result of Injuries sustained in a Covered Accident. The Medical Appliance must be recommended by a Physician or Medical Health Professional and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the Physician or Medical Health Professional must recommend the Medical Appliance within two years of the Covered Accident. This benefit is payable once for any one Medical Appliance per person per Covered Accident.

Medical Appliance means an item that is intended by its manufacturer for use in directly substituting for a malfunctioning part of the body for assistance with mobility. Examples include crutches, wheel chairs and walkers.

PROSTHESIS. The Company will pay a benefit for functional prosthetic limbs that are required by you or an Insured Dependent as a result of Injuries sustained in a Covered Accident. The functional prosthetic limb must be prescribed by a Physician and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the prosthetic limb must be prescribed by a Physician and received within two years of the Covered Accident. This benefit is payable once per limb per person per Covered Accident.

REASONABLE MODIFICATIONS. The Company will pay a benefit for required modifications made to you [or your Insured Dependent's]:

- (1) principal place of residence; or
- (2) vehicle;

provided you [or your Insured Dependent] suffered a Catastrophic Loss, as described in the Schedule of Benefits. Modifications must be made within two years from the date of the Covered Accident. This benefit is payable once per person per Covered Accident.

SPECIMEN

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The Company will pay [one or more of] the following AD&D benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH OR DISMEMBERMENT. The Company will pay an Accidental Death or Dismemberment benefit when you [or your Insured Dependent] sustain[s] an Injury that causes death or dismemberment as a result of a Covered Accident. The Injury must cause death or dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss.

The Accidental Dismemberment Benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when you [or your Insured Dependent] sustain[s] a Common Carrier Accident that results in your [or your Insured Dependent's] death or dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSPORTATION OF REMAINS. The Company will pay a Transportation of Remains benefit if you [or your Insured Dependent] die[s] at least 100 miles from your [or your Insured Dependent's] principal place of residence as a result of a Covered Accident, and the bodily remains or ashes are returned:

- (1) by a company that provides mortuary transport services; and
- (2) to a mortuary or funeral home within 30 miles of the deceased's principal place of residence.

The Company will pay for only one Transportation of Remains benefit per person.

A benefit payable for the transportation of your remains will be paid in accord with the Beneficiary provision. [A benefit payable for the transportation of your Insured Dependent's remains will be paid to you.]

SEAT BELT/HELMET. If you [or your Insured Dependent]:

- (1) [were/was wearing] seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) suffer[s] an AD&D loss;

the Accidental Death or Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

COMMON DISASTER. The Company will pay a Common Disaster benefit if both you and your Insured Dependent Spouse:

- (1) is Injured in the same Covered Accident; and
- (2) lose your lives as a direct result of such Injuries within 365 days of the Common Accident.

The Common Disaster benefit increases your Insured Dependent Spouse's benefit for Accidental loss of life to equal the your Accidental Death Benefit.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when you [or your Insured Dependent] sustain[s] an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment Benefit will not be paid for the same or attached body part.

ACCIDENTAL DISMEMBERMENT BENEFITS

The Company will pay one or more of the following accidental dismemberment benefits if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DISMEMBERMENT. The Company will pay an Accidental Dismemberment benefit when you [or your Insured Dependent] sustain[s] an Injury that causes a dismemberment as a result of a Covered Accident. The Injury must cause dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss

The Accidental Dismemberment Benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when you [or your Insured Dependent] sustain[s] a Common Carrier Accident that results in your [or your Insured Dependent's] dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

SEAT BELT/HELMET. If you [or your Insured Dependent]:

- (1) [were/was] wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) [suffer/suffers] an Accidental Dismemberment;

the Accidental Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when you [or your Insured Dependent] sustain[s] an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

SPECIMEN

LIMITATIONS AND EXCLUSIONS

The Policy covers only Injuries that occur while insurance is in force. Benefits are not payable for any loss if the loss resulting, directly or indirectly, from or was in any degree caused by:

- (1) disease, physical or mental infirmity, Sickness, or medical or surgical treatment of these;
- (2) intentional self-inflicted injury or self-destruction, or any attempt thereof; suicide or suicide attempt, whether sane or insane;
- (3) deliberate use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, except when administered within the therapeutic levels and dosage prescribed by a licensed Physician;
- (4) participation in, commission of or attempt to commit a felony;
- (5) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind; [or Terrorism or any act of Terrorism;]
- (6) duty as a member of any military, including Reserves or National Guard;
- (7) travel or flight in or on any Aircraft, except:
 - (a) as a fare-paying passenger on a regularly scheduled commercial flight; [or
 - (b) as a passenger or pilot in the Group Policyholder's or Participating Organization's aircraft while flying on the Group Policyholder's or Participating Organization's business provided:
 - (i) the aircraft has a valid U.S. airworthiness certificate (or foreign equivalent); and
 - (ii) the pilot has a valid pilot's certificate with a non-student rating authorizing him to fly the aircraft];
- (8) your [or your Insured Dependent] having a blood alcohol level of .08 grams of alcohol or more per 100 milliliters of blood, or being under the influence of any narcotic unless administered or consumed on the advice of a physician;
- [(9) Injury arising out of or in the course of any employment for wage or profit];
- (10) high risk sports or extreme sports such as, but not limited to, bungee jumping, parachuting, base jumping, or mountaineering;
- (11) cosmetic or elective surgery;
- (12) being incarcerated in any type of penal or detention facility;
- (13) participating in or practicing for, or officiating any semi-professional or professional sport;
- (14) riding in or driving a any motor driven vehicle for race, stunt show or speed test; or
- (15) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

"Narcotic" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

- (1) opium, coca leaves, and opiates;
- (2) a compound, manufacture, salt, derivative, or preparation of opium, coca leaves, or opiates; or
- (3) a substance (and any compound, manufacture, salt, derivative, or preparation thereof) which is chemically identical with any of the substances referred to in subsections (1) and (2), except that the words "narcotic drug" as used in the Policy shall not include decocainized coca leaves or extracts of coca leaves, which extracts do not contain cocaine or ecogonine.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At your death, any amount payable as a result of your death will be paid to the named Beneficiary who survives you. If no named Beneficiary survives you, payment will be made to your estate or in accord with the Facility of Payment section.

PAYMENTS TO BENEFICIARY. At your death, any amount payable as a result of your death will be paid to the named Beneficiary who survives you. If you have not named a Beneficiary, or if no named Beneficiary survives you; then payment will be made to your:

- (1) surviving spouse[, domestic partner,] or civil union partner; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving sibling or siblings in equal shares; or, if none
- (5) estate.

If determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

- (1) within 15 days of your death; and
- (2) before the Company receives satisfactory proof of your death;

payment will be made as if you had survived that person, unless other provisions have been made.

NAMING THE BENEFICIARY. Your Beneficiary will be as shown on your enrollment form, unless changed. If the Policy replaces a group policy providing similar coverages; then your beneficiary named under the prior policy will be the Beneficiary under the Policy, until changed.

CHANGING THE BENEFICIARY. Only you or your assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change [with the Company at its Group Insurance Service Office/Group Policyholder] prior to your death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under the Policy becomes payable to your estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

- (1) a person who has assumed the care and support of you or a Beneficiary;
- (2) a person who has incurred expense as a result of your last illness or death;
- (3) the personal representative of your estate; or
- (4) any person related by blood or marriage to you.

No payment made to anyone named above may exceed \$2,000.. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) your name, address and certificate number, if available; and
- (3) the patient's name and relationship to you.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the forms are not received within 15 days; then you may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of services; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

- (1) the nature, date and cause of the claim;
- (2) a description of the services provided; and
- (3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

- (1) any study models, treatment records or charts;
- (2) copies of any x-rays or other diagnostic materials; and
- (3) any other items the Company may reasonably require.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done as soon as reasonably possible. This time limit will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While an Accident claim is pending, the Company may have the claimant examined:

- (1) by a Physician of its choice;
- (2) as often as is reasonably required.

Any such exam will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Accident Benefits payable under this Certificate will be paid immediately after the Company receives the Due Proof of Claim.

TO WHOM PAYABLE

Accidental Death & Dismemberment. Benefits due to loss of your life will be paid in accord with the Beneficiary provision. All other benefits will be paid to you.

[Other] Accident Benefits. Any [other] Accident Benefits will be paid to you; unless[:]

- [(1)] an overpayment has been made and the Company is entitled to reduce future benefits; or
- [(2)] state or federal law requires that benefits be paid to an Insured Dependent child's custodial parent or custodian.]

CLAIM PROCEDURES FOR ACCIDENT INSURANCE
(Continued)

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 60 days after receiving the Due Proof of Claim for [a death] [or other/an] Accident claim.

"Due Proof of Claim" means written proof of the loss that:

- (1) is complete and satisfactory to the Company; and
- (2) includes all items the Company reasonably requires to support the claim.

If the Company requires additional investigation or documentation, the written notification to the claimant must explain what additional information is needed to determine liability and when a decision can be expected. In no event will the claim decision be sent later than 180 days after receiving the first proof of [a death] [or other/an] Accident claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of [a death] [or other/an] Accident claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, then the notice will also describe:

- (1) any further appeal procedures available under the Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a review by the New Jersey Department of Banking and Insurance, at any time; and
- (4) the right to bring legal action at any time, subject to the Legal Actions section shown below.

For [a death] [or other/an] Accident claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 45th day after receiving the request for review. The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal, then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE
(Continued)

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

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