NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

  Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

  The basic coverage protections provided by the Association are as follows.

  - **Life Insurance, Annuities and Structured Settlement Annuities**

    For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

    - Life Insurance

      80% of death benefits but not to exceed $300,000
      80% of cash surrender or withdrawal values but not to exceed $100,000

    - Annuities and Structured Settlement Annuities

      80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

    The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

  - **Health Insurance**

    The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
PO Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

CALIFORNIA NOTICE OF COMPLAINT PROCEDURE

Should any dispute arise about your premium or about a claim that you have filed, write to the company that issued the group policy at:

Standard Insurance Company
PO Box 711
Portland, OR 97207
(971) 321-7000

If the problem is not resolved, you may also write to the State of California at:

Department of Insurance
Consumer Services Division
300 S. Spring Street, 11th FL
Los Angeles, CA 90013
1-800-927-HELP (4357)

This notice of complaint procedure is for information only and does not become a part or condition of this group policy/certificate.

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon
(503) 321-7000

GROUP ACCIDENT INSURANCE CERTIFICATE

AND SUMMARY PLAN DESCRIPTION

Policyholder:	Orange County Employees Association Health and Welfare Trust
Group Policy Number:	762040-A
Group Policy Effective Date:	January 1, 2024
State of Issue:	California

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of the Group Policy. If your insurance is changed by an amendment to the Group Policy, we will provide the Policyholder or Employer with a revised Certificate and Summary Plan Description or other notice that will be available to you.

Possession of this Certificate and Summary Plan Description does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate and Summary Plan Description.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

Your Certificate and Summary Plan Description describes the insurance under the Group Policy. Please read your Certificate carefully.

THIS CERTIFICATE IS ISSUED UNDER A LIMITED BENEFIT POLICY THAT PROVIDES ACCIDENT INSURANCE BENEFITS AND IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL HEALTH LAW. IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, SURGICAL, OR MAJOR MEDICAL EXPENSES.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

STANDARD INSURANCE COMPANY
By

President and CEO

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INDEX OF DEFINED TERMS

COVERAGE FEATURES

Employer(s)

Orange County Employees Association Health and Welfare Trust

Member

You are a Member if you are all of the following:

- An active employee in a regular or limited term position who is regularly scheduled to work at least 20 hours each week and for whom Orange County Employees Association receives a health and welfare contribution from Orange County.
- An active staff member of Orange County Employees Association who is regularly working at least 20 hours each week and who has met the probationary period stipulated by Orange County Employees Association.
- An active Orange County Employees Association member who is a dues paying member and working for a Health and welfare employer, regularly working at least 20 hours each week.
- A citizen or resident of the United States.

You are not a Member if you are:

- A temporary or seasonal employee.
- A full time member of the armed forces of any country.
- A leased employee.
- An independent contractor.
- An extra help employee.

Class(es)

All Members

Work (Occupational) Accident Covered: Yes

Eligibility Waiting Period

If you are a Member on the Group Policy Effective Date, you are eligible on that date.

If you become a Member after the Group Policy Effective Date, you are eligible on the date you become a Member.

Premium Contributions

For you and your Dependents: Contributory

Contributory means you pay all or part of the premium for insurance.

Table Of Accident Insurance Benefit Amounts

Emergency Care Benefits

Air Ambulance Benefit	$800
Blood, Plasma, and Platelet Benefit	$300

Emergency Dental Benefit		
Crown	$200	
Extraction	$100	
Emergency Room Benefit	$150	
Ground Ambulance Benefit	$300	
Initial Care Visit Benefit	$50	
Major Diagnostic Exam Benefit	$200	
Outpatient X-Ray Benefit	$50	
Urgent Care Benefit	$50	

Specific Injury Benefits

Burn Benefit		
2nd degree burn less than or equal to 15% of body surface	$200	
2nd degree burn greater than 15% of body surface	$1,000	
3rd degree burn less than or equal to 15% of body surface	$5,000	
3rd degree burn greater than 15% of body surface	$10,000	
Coma Benefit	$7,500	
Concussion Benefit	$150	
Dislocation Benefit	**Non-surgical**	**Surgical**
Ankle	$800	$1,600
Collarbone (sternocalvicular)	$800	$1,600
Collarbone (acromio and separation)	$400	$800
Elbow	$800	$1,600
Finger(s)	$150	$300
Foot (not including toe(s))	$800	$1,600
Hand (not including finger(s))	$800	$1,600
Hip	$2,500	$5,000
Knee (not including kneecap)	$900	$1,800
Lower jaw	$800	$1,600
Rib	$150	$300
Shoulder	$800	$1,600
Spine	$400	$800
Toe(s)	$150	$300
Wrist	$800	$1,600

Partial Dislocation	25% of the non-surgical amount payable for the specific Dislocation amount shown above	
Eye Injury Benefit	$200	
Fracture Benefit	**Non-surgical**	**Surgical**
Ankle	$550	$1,100
Arm (elbow to wrist)	$550	$1,100
Arm (shoulder to elbow)	$550	$1,100
Bones of face (other than lower jaw or nose)	$500	$1,000
Coccyx	$500	$1,000
Collarbone	$550	$1,100
Elbow	$550	$1,100
Finger(s)	$100	$200
Foot (not including toe(s))	$550	$1,100
Hand (not including finger(s))	$550	$1,100
Hip	$2,500	$5,000
Kneecap	$550	$1,100
Leg (knee to ankle)	$1,200	$2,400
Leg (hip to knee)	$2,000	$4,000
Lower jaw	$550	$1,100
Nose	$500	$1,000
Pelvis	$1,200	$2,400
Rib	$400	$800
Shoulder blade	$550	$1,100
Skull		
Depressed	$4,000	$8,000
Non-depressed	$1,500	$3,000
Sternum	$550	$1,100
Toe(s)	$100	$200
Vertebrae	$500	$1,000
Vertebral Column	$1,200	$2,400
Wrist	$550	$1,100
Chip Fracture	25% of the non-surgical amount payable for the specific Fracture shown above	
Laceration Benefit		
Less than 2 inches combined length for all lacerations	$75	

2-6 inches combined length for all lacerations	$200
Over 6 inches combined length for all lacerations	$500
Skin Graft Benefit	25% of Burn Benefit

Surgical Benefits

Abdominal and Thoracic Surgery Benefit	
Exploratory surgery (both laparoscopic and open)	$200
Laparoscopic surgical repair	$750
Open surgical repair	$1,500
Knee Cartilage Benefit	
Exploratory surgery	$200
One surgical repair	$750
Ruptured Disc Benefit	$750
Surgical Facility Benefit	$150
Tendon, Ligament, and Rotator Cuff Surgery Benefit	
Exploratory of any of the above	$200
Repair of one of the above	$750
Repair of more than one of the above	$1,000

Hospital Benefits

Critical Care Unit Admission Benefit	$750
Daily Critical Care Unit Confinement Benefit	$200 per day
Daily Hospital Confinement Benefit	$200 per day
Daily Rehabilitation Facility Benefit	$100 per day
Hospital Admission Benefit	$1,000

Follow Up Care Benefits

Appliance Benefit	$100
Chiropractic Care Benefit	$50 per day
Follow Up Care Benefit	$50 per day
Hearing Device Benefit	$500
Prosthesis Benefit	
One Prosthetic	$500
More than one Prosthetic	$1,000
Therapy Services Benefit	$50 per day

Additional Benefits

Automobile Accident Benefit	$500
Health Maintenance Screening Benefit	$200 per day
Lodging Benefit	$175 per day
Transportation Benefit	$150 per day
Youth Organized Sports Benefit	25% of total Covered Accident benefits payable for Child

Accidental Death and Dismemberment (AD&D) Benefits

Accidental Death Benefit (AD Benefit)	
For you:	$50,000
For your Spouse:	$25,000
For your Child(ren):	$12,500
Accidental Dismemberment Benefit	
One hand or one foot	15% of AD Benefit, rounded up to the next multiple of $1,000, if not already a multiple of $1,000.
Both hands or feet	30% of AD Benefit, rounded up to the next multiple of $1,000, if not already a multiple of $1,000.
One hand and one foot	30% of AD Benefit, rounded up to the next multiple of $1,000, if not already a multiple of $1,000.
One finger or toe	2% of AD Benefit, rounded up to the next multiple of $1,000, if not already a multiple of $1,000.
More than one finger or toe	5% of AD Benefit, rounded up to the next multiple of $1,000, if not already a multiple of $1,000.
Accidental Impairment Benefit	
Loss Of Hearing	
One ear	15% of AD Benefit
Both ears	30% of AD Benefit
Loss Of Sight	
One eye	15% of AD Benefit
Both eyes	30% of AD Benefit
Hemiplegia	30% of AD Benefit
Paraplegia	30% of AD Benefit
Quadriplegia	50% of AD Benefit
Triplegia	30% of AD Benefit
Uniplegia	15% of AD Benefit

Value Added AD&D Benefits

Airbag Benefit	10% of AD Benefit
Common Carrier Accidental Benefit	100% of AD Benefit

Helmet Benefit	10% of AD Benefit
Line Of Duty Benefit	100% of AD&D Benefit
Repatriation Benefit	10% of AD Benefit
Seat Belt Benefit	10% of AD Benefit

Additional Features

Reinstatement

Continuity of Coverage

Continuation of Insurance (Portability) for the Member

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan:	Group Accident Insurance
Name, Address of Plan Sponsor:	Orange County Employees Association Health and Welfare Trust 830 Ross Street Santa Ana, California 92701
Plan Sponsor Tax ID Number:	33-0660405
Plan Number:	501
Type of Plan:	Group Insurance Plan
Type of Administration:	Contract Administration
Name, Address, Phone Number of Plan Administrator:	Plan Sponsor (714) 835-3333
Name, Address of Registered Agent for Service of Legal Process:	Orange County Employees Association Health and Welfare Trust
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 900 SW Fifth Avenue Portland, Oregon
Sources of Contributions:	Member
Funding Medium:	Standard Insurance Company - Fully Insured
Plan Fiscal Year End:	December 31

ELIGIBILITY AND ENROLLMENT

Becoming Insured

To become insured you must:

- Be a Member.
- Complete your Eligibility Waiting Period.
- Meet the requirements shown in **When Your Insurance Becomes Effective** and **Active Work Requirement**.

When Your Insurance Becomes Effective

The **Coverage Features** states whether insurance is Contributory or Noncontributory. Subject to the **Active Work Requirement**, your insurance becomes effective as follows:

Contributory Insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance becomes effective on:

- The date you become eligible if you apply on or before that date.
- The date you apply if you apply after you become eligible.

Changes in Your Insurance

Subject to the **Active Work Requirement**, you may apply in writing for any increase in your insurance, for which you are eligible.

Decreases become effective on the later of:

- The first day of the calendar month coinciding with or next following the date of change in your Class.
- The first day of the calendar month coinciding with or next following the date the Policyholder or Employer receives your written request for the decrease.

Active Work Requirement

If you are incapable of Active Work because of Sickness, on the day before the scheduled effective date of your insurance under the Group Policy, your insurance will not become effective until the day after you complete 1 full day(s) of Active Work as an eligible Member.

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the **Active Work Requirement** if you meet all of the requirements shown below:

- You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day.
- You were Actively At Work on your last scheduled work day before the date of your absence.
- You were capable of Active Work on the day before the scheduled effective date of your insurance.

When Your Insurance Ends

Insurance ends automatically on the earliest of the following:

- For Contributory insurance, the date you notify your Employer or Policyholder in writing that coverage is to be terminated.
- The date the last period ends for which the premium was paid for your insurance.

- The date the Group Policy or your Employer's coverage under the Group Policy terminates, unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The first day of the calendar month following the date your employment terminates, unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued with payment of premium:
  - During the first 60 day(s) of a temporary or indefinite administrative leave of absence or sick leave.
  - During any other scheduled leave of absence approved by your Employer in advance and in writing and lasting not more than 60 day(s).
  - During a leave of absence which is required by the federal or a state-mandated family or medical leave act or law.

CHILD INSURANCE

Eligibility for Child Insurance

You become eligible to insure your Child(ren) on the later of:

- The date your insurance becomes effective if you have a Child on that date.
- The date you first acquire a Child, if you are insured on that date.

A Member may not be insured as both a Member and a Child. A Child may not be insured by more than one Member.

For Contributory Child insurance, if you do not have Child insurance at the time you acquire a newborn or adopted Child, that Child is automatically insured for 31 days from the moment of birth or placement. However, you must apply in writing and pay premium back to the date of birth or placement within 31 days for Child insurance to continue. If your application is received after that 31 days, your automatic Child insurance under this provision ends on the first day after the 31 day period. This provision does not apply to you if you have an existing Child and you previously declined to enroll in Child insurance.

When Child Insurance Becomes Effective

The **Coverage Features** states whether your Child insurance is Contributory or Noncontributory. You must apply in writing for Contributory Child insurance and agree to pay premiums.

Contributory Child insurance becomes effective on the latest of:

- The date your insurance becomes effective if you have a Child on that date and you have applied for Child insurance.
- The first day of the calendar month coinciding with or next following the date you apply to insure your Child.

Changes in Child Insurance

Increases or decreases resulting from changes in your insurance will become effective for the Child on the effective date of your change in insurance.

When Child Insurance Ends

Your insurance for a Child ends automatically on the earliest of:

- The date your insurance ends, unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

- The date the Child insurance terminates under the Group Policy, unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date a Child ceases to meet the definition of Child.
- The date the last period ends for which the premium was paid for your Child insurance.
- The date the Group Policy terminates or the date your Employer's coverage under the Group Policy terminates, unless Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

SPOUSE INSURANCE

Eligibility for Spouse Insurance

You become eligible to insure your Spouse on the later of:

- The date you become eligible for insurance if you have a Spouse on that date.
- The date you acquire a Spouse if you are insured on that date.

A Member may not be insured as both a Member and a Spouse.

When Spouse Insurance Becomes Effective

The **Coverage Features** states whether your Spouse insurance is Contributory or Noncontributory. You must apply in writing for Contributory Spouse insurance and agree to pay premiums.

Contributory Spouse insurance becomes effective on the latest of:

- The date your insurance becomes effective if you apply on or before that date to insure your Spouse.
- The first day of the calendar month coinciding with or next following the date you apply to insure your Spouse.

Changes in Spouse Insurance

Increases or decreases resulting from changes in your insurance will become effective for your Spouse on the effective date of your change in insurance.

When Spouse Insurance Ends

Your insurance for a Spouse ends automatically on the earliest of:

- The date your insurance ends, unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date Spouse insurance terminates under the Group Policy.
- The date a Spouse ceases to meet the definition of Spouse.
- The date the last period ends for which the premium was paid for your Spouse insurance.
- The date the Group Policy terminates, unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

ACCIDENT INSURANCE BENEFITS

Insuring Clause

If you or your Dependent meet the requirements for Accident Insurance Benefits while insured under the Group Policy, we will pay benefits according to the terms of the Group Policy after we receive Proof Of Loss.

Emergency Care Benefits

Air Ambulance Benefit

We will pay an Air Ambulance Benefit if you or your Dependent meet all of the following requirements:

- Transportation via air Ambulance is for the same Covered Accident for which a Daily Hospital Confinement Benefit, Hospital Admission Benefit, or Emergency Room Benefit is payable.
- Transportation is to a Hospital or Health Service Facility within 72 hours of the Covered Accident.

We will pay an Air Ambulance Benefit once per Covered Accident per insured person. A Ground Ambulance Benefit and Air Ambulance Benefit may be payable for the same Covered Accident.

Blood, Plasma, and Platelet Benefit

We will pay a Blood, Plasma, and Platelet Benefit if you or your Dependent meet all of the following requirements:

- Require a transfusion of blood, plasma, or platelets (including, the administration, cross matching, typing, and processing of blood, plasma, or platelets) for a Covered Accident.
- The transfusion is administered within 90 days of the Covered Accident.

We will pay a Blood, Plasma, and Platelet Benefit once per Covered Accident per insured person.

Emergency Dental Benefit

We will pay an Emergency Dental Benefit if you or your Dependent meet all of the following requirements:

- Suffer one or more broken teeth as a result of a Covered Accident which is repaired by a Dentist with dental crown(s) and/or dental extraction(s).
- Repair must begin within 90 days of the Covered Accident.

We will pay an Emergency Dental Benefit for 1 dental crown(s) and 1 dental extraction(s) per Covered Accident per insured person, regardless of how many dental crowns and dental extractions occur. We will not pay for routine dental examinations or procedures.

Dentist means a licensed doctor of dentistry, acting within the scope of the license. Dentist does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Emergency Room Benefit

We will pay an Emergency Room Benefit if you or your Dependent meet all of the following requirements:

- Visit an Emergency Room for a Covered Accident.
- The visit is within 72 hours of the Covered Accident.

We will pay an Emergency Room Benefit once per Covered Accident per insured person.

Ground Ambulance Benefit

We will pay a Ground Ambulance Benefit if you or your Dependent meet all of the following requirements:

- Transportation via ground Ambulance is for the same Covered Accident for which a Daily Hospital Confinement Benefit, Hospital Admission Benefit, or Emergency Room Benefit is payable.
- Transportation is to a Hospital or Health Service Facility within 90 days of the Covered Accident.

We will pay a Ground Ambulance Benefit once per Covered Accident per insured person. A Ground Ambulance Benefit and Air Ambulance Benefit may be payable for the same Covered Accident.

Initial Care Visit Benefit

We will pay an Initial Care Visit Benefit if you or your Dependent meet all of the following requirements:

- Visit a Health Care Provider for Initial Care due to a Covered Accident.

- The visit is within 72 hours of the Covered Accident.

We will pay an Initial Care Visit Benefit once per Covered Accident per insured person.

An Initial Care Visit Benefit is not payable if:

- Initial Care is rendered in an Urgent Care Facility or Emergency Room and an Urgent Care Benefit or Emergency Room Benefit is payable for the same Covered Accident.
- Initial Care occurs in a Health Care Provider's office or clinic and a subsequent visit is made for the same Covered Accident to an Urgent Care Facility or Emergency Room within 24 hours of the Initial Care and an Urgent Care Benefit or Emergency Room Benefit is payable for the same Covered Accident.

Major Diagnostic Exam Benefit

We will pay a Major Diagnostic Exam Benefit if you or your Dependent meet all of the following requirements:

- Undergo a Major Diagnostic Exam due to a Covered Accident.
- The Major Diagnostic Exam is performed within 90 days of the Covered Accident.

Major Diagnostic Exam means:

- Computerized Tomography (CT) scan.
- Magnetic Resonance Imaging (MRI).
- Electroencephalogram (EEG).
- Magnetic Resonance Angiogram scan (MRA).
- Positron Emission Tomography (PET).
- Spectroscopy (SPECT).

We will pay a Major Diagnostic Exam Benefit once per Covered Accident per insured person, regardless of the number of Major Diagnostic Exams.

Outpatient X-Ray Benefit

We will pay an Outpatient X-Ray Benefit if you or your Dependent meet all of the following requirements:

- Undergo an X-ray due to a Covered Accident.
- An X-ray was performed on an Outpatient basis at a Hospital or Health Service Facility within 90 days of the Covered Accident.

We will pay an Outpatient X-Ray Benefit once per Covered Accident per insured person.

Urgent Care Benefit

We will pay an Urgent Care Benefit if you or your Dependent meet all of the following requirements:

- Visit an Urgent Care Facility due to a Covered Accident.
- The visit is within 72 hours of the Covered Accident.

We will pay an Urgent Care Benefit once per Covered Accident per insured person. An Urgent Care Benefit is not payable if an Emergency Room Benefit is payable for the same Covered Accident.

Specific Injury Benefits

Burn Benefit

We will pay a Burn Benefit if you or your Dependent meet all of the following requirements:

- Sustain a second or third degree burn as a result of a Covered Accident.

- Treated by a Physician within 72 hours of the Covered Accident.

We will pay a Burn Benefit once per Covered Accident per insured person. If you or your Dependent sustain a second degree and third degree burn for the same Covered Accident, we will pay both benefit amounts.

Coma Benefit

We will pay a Coma Benefit if you or your Dependent sustain a Coma due to a Covered Accident. We will pay a Coma Benefit once per Covered Accident per insured person.

Coma means a diagnosis for which there is a profound state of mental unconsciousness from which one cannot be aroused and there is no evidence of appropriate response to external stimulation, other than primitive avoidance reflexes. The diagnosis must:

- Be made by a Physician.
- Must last for at least 96 consecutive hours resulting in neurological deficit with persisting clinical symptoms.

Coma which is medically induced or coma as a result of Substance Abuse is not included.

Concussion Benefit

We will pay a Concussion Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Concussion as a result of a Covered Accident.
- The diagnosis is made by a Physician within 72 hours of the Covered Accident.

We will pay a Concussion Benefit once per Covered Accident per insured person.

Concussion means a disruption of brain function resulting from a traumatic blow to the head, neck, or upper body.

Dislocation Benefit

We will pay a Dislocation Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Dislocation or Partial Dislocation as a result of a Covered Accident and it is diagnosed within 90 days of the Covered Accident.
- The Dislocation or Partial Dislocation must require a surgical or nonsurgical procedure by a Physician.
- If a surgical procedure is required, the procedure must begin within 90 days of the Covered Accident.

We will pay a Dislocation Benefit for each Dislocation and Partial Dislocation per Covered Accident per insured person.

Dislocation or Dislocated means a separation of two bones where they meet at a joint.

Partial Dislocation means the partial, abnormal separation of the articular surfaces of a joint. Also, referred to as an incomplete dislocation or subluxation.

Eye Injury Benefit

We will pay an Eye Injury Benefit if you or your Dependent meet one of the following requirements:

- Surgical repair of an eye is performed by a Physician due to a Covered Accident within 90 days of a Covered Accident.
- A Physician removes an embedded foreign body from the eye (with or without anesthesia) due to a Covered Accident within 90 days of a Covered Accident.

We will pay an Eye Injury Benefit once per eye per Covered Accident per insured person. The Eye Injury Benefit is not payable solely for an Injury to the eyelid or for an examination of the eye.

Fracture Benefit

We will pay a Fracture Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Fracture or Chip Fracture as a result of a Covered Accident and it is diagnosed within 90 days of the Covered Accident.
- The Fracture or Chip Fracture must be corrected by a surgical or nonsurgical procedure by a Physician.
- If a surgical procedure is required, the procedure must begin within 90 days of the Covered Accident.

We will pay a Fracture Benefit for each Fracture and Chip Fracture suffered per Covered Accident per insured person.

Chip Fracture means any small fragmental Fracture, usually one involving a bony process near a joint.

Fracture means a break in a bone which is confirmed by X-ray or other diagnostic examination.

Laceration Benefit

We will pay a Laceration Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Laceration as a result of a Covered Accident and it is treated within 72 hours of the Covered Accident.
- A wound closure is performed by a Health Care Provider to repair the Laceration. Wound closure includes, but is not limited to: staples, sutures, stitches, glue, or steristrips.

We will pay a Laceration Benefit once per Covered Accident per insured person. The amount payable is the total length of all lacerations received in any one Covered Accident per insured person.

Laceration means a cut.

Skin Graft Benefit

We will pay a Skin Graft Benefit if you or your Dependent meet all of the following requirements:

- A Burn Benefit is payable for the same Covered Accident.
- Skin grafting is performed by a Physician to repair the Injury.

We will pay a Skin Graft Benefit once per Covered Accident per insured person.

Surgical Benefits

Abdominal and Thoracic Surgery Benefit

We will pay an Abdominal and Thoracic Surgery Benefit if you or your Dependent meet all of the following requirements:

- An abdominal or thoracic surgery is performed by a Physician due to Injuries sustained in a Covered Accident.
- The surgery is performed within 72 hours of a Covered Accident.

We will pay an Abdominal and Thoracic Surgery Benefit once per Covered Accident per insured person. If more than one abdominal or thoracic surgery is performed as a result of the same Covered Accident, we will pay the benefit for the surgery with the highest payable benefit amount.

Knee Cartilage Benefit

We will pay a Knee Cartilage Benefit if you or your Dependent meet one of the following requirements:

- Undergo exploratory surgery by a Physician for a suspected tear, rupture, or severance of the knee cartilage of one or both knees due to a Covered Accident within 90 days after the Covered Accident.

- Suffer a tear, rupture or severance of the knee cartilage of one or both knees due to a Covered Accident with diagnosis within 90 days after the Covered Accident with surgical repair by a Physician completed within 180 days of the Covered Accident.

We will pay a Knee Cartilage Benefit once per Covered Accident per insured person, regardless of whether one or both knees require surgical repair. If exploratory and surgical repair are performed for the same Covered Accident, we will pay the surgical repair benefit amount.

Knee Cartilage means the fibrous cartilage contained in the knee, known as the meniscus.

Ruptured Disc Benefit

We will pay a Ruptured Disc Benefit if you or your Dependent meet all of the following requirements:

- Suffer at least one ruptured disc in the spinal column as a result of a Covered Accident for which surgery is required.
- The ruptured disc must be treated by a Physician within 90 days of a Covered Accident, with completion of the surgery within 180 days of a Covered Accident.

We will pay a Ruptured Disc Benefit once per Covered Accident per insured person, regardless of the number of discs ruptured.

Surgical Facility Benefit

We will pay a Surgical Facility Benefit if you or your Dependent meet all of the following requirements:

- Surgery is performed by a Physician for a Covered Accident.
- Surgery for a Covered Accident is performed on an Outpatient basis at a Hospital or an Ambulatory Surgical Center.
- Surgery is within 90 days of the Covered Accident.

We will pay a Surgical Facility Benefit once per Covered Accident per insured person.

Tendon, Ligament, and Rotator Cuff Surgery Benefit

We will pay a Tendon, Ligament, and Rotator Cuff Surgery Benefit if you or your Dependent meet one of following requirements:

- Undergo exploratory surgery by a Physician for an Injury of the tendon, ligament, or rotator cuff due to a Covered Accident within 90 days of the Covered Accident.
- Suffer an Injury of the tendon, ligament, or rotator cuff due to a Covered Accident with diagnosis within 90 days after the Covered Accident with surgical repair by a Physician completed within 180 days of the Covered Accident.

We will pay a Tendon, Ligament, and Rotator Cuff Surgery Benefit once per Covered Accident per insured person. If we pay for one surgical repair and a second surgical repair is required for the same Covered Accident and the requirements above are met, we will pay the difference between the amount already paid for the first surgical repair and the amount due for the second surgical repair. If an exploratory and surgical repair are performed for the same Covered Accident, we will pay the surgical repair amount.

Hospital Benefits

Critical Care Unit Admission Benefit

We will pay a Critical Care Unit Admission Benefit if you or your Dependent meet all of the following requirements:

- Admitted by a Physician to a Critical Care Unit due to a Covered Accident.
- Admission occurs within 90 days of a Covered Accident for diagnosis or treatment of Injuries sustained in a Covered Accident.

We will pay a Critical Care Unit Admission Benefit once per Covered Accident per insured person, regardless of the number of days Confined in the Critical Care Unit. The Critical Care Unit Admission Benefit may be paid in addition to the Hospital Admission Benefit.

Daily Critical Care Unit Confinement Benefit

We will pay a Daily Critical Care Unit Confinement Benefit for the days you or your Dependent meet all of the following requirements:

- Confined to a Critical Care Unit of a Hospital due to a Covered Accident.
- Confinement occurs within 15 days of a Covered Accident.

We will pay a Daily Critical Care Unit Confinement Benefit for up to 15 days per Covered Accident per insured person. A Daily Critical Care Unit Confinement Benefit may be paid in addition to a Daily Hospital Confinement Benefit.

Only one Daily Critical Care Unit Confinement Benefit is payable at a time, even if Confinement is caused by more than one Covered Accident.

Daily Hospital Confinement Benefit

We will pay a Daily Hospital Confinement Benefit for the days you or your Dependent meet all of the following requirements:

- Confined to a Hospital due to a Covered Accident.
- Confinement occurs within 15 days of the Covered Accident.

We will pay a Daily Hospital Confinement Benefit for up to 365 days per Covered Accident per insured person.

Only one Daily Hospital Confinement Benefit is payable at a time, even if Confinement is caused by more than one Covered Accident.

Daily Rehabilitation Facility Benefit

We will pay a Daily Rehabilitation Facility Benefit for the days you or your Dependent meet all of the following requirements:

- A Physician prescribes Confinement in a Rehabilitation Facility providing rehabilitation care services due to a Covered Accident.
- Confinement in the Rehabilitation Facility immediately follows a Confinement in a Hospital due to a Covered Accident.

We will pay a Daily Rehabilitation Facility Benefit for up to 90 days per Covered Accident per insured person.

A Daily Rehabilitation Facility Benefit is not payable if a Daily Hospital Confinement Benefit or Daily Critical Care Unit Benefit is payable for the same days of the same Covered Accident.

Only one Daily Rehabilitation Facility Benefit is payable at a time, even if Confinement is caused by more than one Covered Accident.

Hospital Admission Benefit

We will pay a Hospital Admission Benefit if you or your Dependent meet all of the following requirements:

- Admitted by a Physician to a Hospital due to a Covered Accident.
- Admission occurs within 90 days of the Covered Accident.

We will pay a Hospital Admission Benefit once per Covered Accident per insured person, regardless of the number of days Confined in a Hospital. The Hospital Admission Benefit may be paid in addition to the Critical Care Unit Admission Benefit.

Follow Up Care Benefits

Appliance Benefit

We will pay an Appliance Benefit if you or your Dependent meet all of the following requirements:

- Use an Appliance as prescribed by a Physician, Physical Therapist, or Occupational Therapist as necessary due to an Injury sustained in a Covered Accident.
- Use of the Appliance is within 90 days of the Covered Accident.

We will pay an Appliance Benefit for 1 Appliance(s) per Covered Accident per insured person.

Appliance means a wheelchair, leg or back brace, crutches, walker, cane, a walking boot that extends above the ankle, or a brace for the neck.

Chiropractic Care Benefit

We will pay a Chiropractic Care Benefit if you or your Dependent meet all of the following requirements:

- Suffer a structural imbalance as a result of a Covered Accident and receive chiropractic care services from a Chiropractor in a chiropractic office.
- Visit the Chiropractor within 90 days of the Covered Accident and receive initial treatment within 90 days of a Covered Accident, with completion of the follow up treatment within 365 days of the Covered Accident.

We will pay a Chiropractic Care Benefit for up to 2 day(s) per Covered Accident per insured person.

Chiropractor means an individual who has obtained a professional degree in chiropractic care, is licensed by the state and performs chiropractic services acting within the scope of the license. Chiropractor does not include you or your Spouse or the brother, sister, parent or child of either you or your Spouse.

Follow Up Care Benefit

We will pay a Follow Up Care Benefit if you or your Dependent meet all of the following requirements:

- Visit a Health Care Provider for Follow Up Care of a Covered Accident.
- The Follow Up Care occurs within 90 days after Initial Care for the same Covered Accident, with completion of the Follow Up Care within 365 days of the Initial Care.

We will pay a Follow Up Care Benefit for up to 2 day(s) per Covered Accident per insured person.

A Follow Up Care Benefit is not payable if Follow Up Care is rendered in an Urgent Care Facility or Emergency Room and an Urgent Care Benefit or Emergency Room Benefit is payable for the same Covered Accident.

Follow Up Care means a visit to a Health Care Provider for ongoing medical services due to a Covered Accident. Follow Up Care does not include occupational therapy, speech therapy, physical therapy, or chiropractic treatment.

Hearing Device Benefit

We will pay a Hearing Device Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Moderate Loss Of Hearing due to a Covered Accident and not due to the natural aging process.
- A licensed hearing aid specialist, audiologist, or a Diplomate of the American Board of Otolaryngology recommends a Hearing Device for a Covered Accident within 90 days of a Covered Accident.
- A Hearing Device is procured within 365 days of the recommendation.

We will pay a Hearing Device Benefit once per Covered Accident per insured person.

Hearing Device means an electronic device worn in or on the ear to help a person who has hearing loss to improve one's ability to hear.

Moderate Loss Of Hearing means a loss of between 56-70 dB as certified by a licensed hearing aid specialist, audiologist, or a Diplomate of the American Board of Otolaryngology.

Prosthesis Benefit

We will pay a Prosthesis Benefit if you or your Dependent meet all of the following requirements:

- Sustain Injuries due to a Covered Accident for which you or your Dependent receive one or more prosthetic devices or artificial limbs as prescribed by a Physician for functional use.
- Receive an Accidental Dismemberment Benefit for the same Covered Accident for which the prosthetic device or artificial limb replaces.
- The prosthetic devices or artificial limbs must be prescribed by a Physician and received within 365 days of the Covered Accident.

The following are not prosthetic devices or artificial limbs:

- Hearing Devices.
- Dental aids (including false teeth).
- Eyeglasses.
- Artificial joints (including but not limited to hip and knee replacements).
- Cosmetic prosthesis such as hair wigs.

We will pay a Prosthesis Benefit once per Covered Accident per insured person.

Therapy Services Benefit

We will pay a Therapy Services Benefit if you or your Dependent meet all of the following requirements:

- A Health Care Provider prescribes occupational, speech or physical therapy by a licensed Occupational, Speech, or Physical Therapist due to a Covered Accident.
- Treatment must begin within 90 days of the Covered Accident and must be completed within 365 days.

We will pay a Therapy Services Benefit for up to 3 day(s) per Covered Accident per insured person.

Additional Benefits

Automobile Accident Benefit

We will pay an Automobile Accident Benefit if you or your Dependent meet all of the following requirements:

- Travel in an Automobile involved in a Covered Accident resulting in Injury or death and for which another Accident Insurance Benefit is payable for the same Covered Accident.
- The driver of that Automobile has a current and valid driver's license at the time of the Covered Accident.
- The driver is operating that Automobile within the legal speed limit and in compliance with other traffic laws in the jurisdiction in which the Covered Accident occurred.

The Automobile Accident Benefit is payable once per Covered Accident, regardless of the number of insured persons traveling in the Automobile.

Health Maintenance Screening Benefit

We will pay a Health Maintenance Screening Benefit if you or your Dependent meet all of the following requirements:

- A Health Maintenance Screening Procedure is performed.

Health Maintenance Screening Procedures are limited to the following:

- Abdominal aortic aneurysm ultrasound.

- Ankle Brachial Index (ABI) screening for peripheral vascular disease.
- Biopsies for cancer.
- Bone density screening.
- Breast ultrasound.
- Cancer antigen 125 blood test for ovarian cancer (CA 125).
- Cancer antigen 15-3 blood test for breast cancer (CA 15-3).
- Carcinoembryonic antigen blood test for colon cancer (CEA).
- Colonoscopy.
- Complete Blood Count (CBC).
- Comprehensive Metabolic Panel (CMP).
- Electrocardiogram (EKG).
- Hemocult stool analysis.
- Hemoglobin AIC.
- Human Papillomavirus (HPV) vaccination.
- Lipid panel.
- Mammography.
- Pap smears or thin prep pap test.
- Prostate specific antigen (PSA) test.
- Stress test on a bicycle or treadmill.
- Mental health assessments, including but not limited to, PHQ-9, Beck's Depression Inventory, Hamilton's Depression Rating Scale.
- Novel infectious disease testing, including testing for antibodies related to novel infectious diseases.

We will pay a Health Maintenance Screening Benefit for 1 day(s) per insured person per Calendar Year.

Lodging Benefit

We will pay a Lodging Benefit for the days you or your Dependent meet all of the following requirements:

- Travel at least 50 miles from your or your Dependent's residence to a place for treatment due to a Covered Accident and for which another Accident Insurance Benefit is payable.
- A lodging expense is incurred by you or your Dependent or another person.

We will pay you a Lodging Benefit for up to 30 days per Covered Accident per insured person. We will pay a total of 90 days during any 365 day period.

Transportation Benefit

We will pay a Transportation Benefit for the days you or your Dependent meet all of the following requirements:

- Travel at least 50 miles from your or your Dependent's residence to a place for treatment due to a Covered Accident.
- Another Accident Insurance Benefit is payable for the same Covered Accident.

We will pay a Transportation Benefit for up to 30 days per Covered Accident per insured person. We will pay a total of 90 days during any 365 day period. The Transportation Benefit is not payable for travel in an Ambulance.

Youth Organized Sports Benefit

We will pay a Youth Organized Sports Benefit if all of the following requirements are met:

- While your Child is participating in an Organized Sport Event or scheduled practice, the Child suffers a Covered Accident and for which another Accident Insurance Benefit is payable for the same Covered Accident.
- Your Child is age 18 or younger.
- You provide proof of your Child's registration in the Organized Sport Event.

We will pay a Youth Organized Sports Benefit once per Covered Accident per Child.

Organized Sport Event means a physical activity which is governed by an organization and requires formal registration to participate. This may include school, church, or other recreational leagues.

AD&D Benefits

Accidental Death Benefit

We will pay an Accidental Death Benefit if you or your Dependent meet all of the following requirements:

- Death is caused or substantially contributed by a Covered Accident.
- The death occurs within 365 days after the Covered Accident.

Death will be presumed if you or your Dependent disappear and the disappearance:

- Is caused or substantially contributed by a Covered Accident that reasonably could have caused death.
- Continues for a period of 365 days after the date of the Covered Accident, despite reasonable search efforts.

Accidental Dismemberment Benefit

We will pay an Accidental Dismemberment Benefit if you or your Dependent meet all of the following requirements:

- As a result of a Covered Accident suffer one of the following dismemberments:
  - One hand and one foot.
  - Both hands or feet.
  - One hand or one foot.
  - One finger or toe.
  - More than one finger or toe.

  With respect to a hand or foot, dismemberment means actual and permanent severance from the body at or above the wrist or ankle joints, whether or not surgically reattached; or permanent, complete and irreversible loss of function.

  With respect to finger(s), dismemberment means actual and permanent severance from the body at or above the metacarpophalangeal joints, whether or not surgically reattached; or permanent, complete and irreversible loss of function.

  With respect to toe(s), dismemberment means actual and permanent severance from the body at or above the metatarsophalangeal joints, whether or not surgically reattached; or permanent, complete and irreversible loss of function.

  An Accidental Dismemberment Benefit is not payable for the dismemberment of fingers of the same hand if an Accidental Dismemberment Benefit is payable for the dismemberment of the entire hand.

An Accidental Dismemberment Benefit is not payable for the dismemberment of toes of the same foot if an Accidental Dismemberment Benefit is payable for the dismemberment of the entire foot.

- The dismemberment occurs within 365 days of the Covered Accident.

In the event you or your Dependent suffer more than one dismemberment as a result of the same Covered Accident, we will pay the applicable percentage for each dismemberment as shown in the Table Of Accident Insurance Benefit Amounts in the **Coverage Features**, not to exceed a total of 100% of the Accidental Death Benefit amount.

No Accidental Dismemberment Benefit will be paid for loss of function of a hand or foot if an Accidental Impairment Benefit is payable involving the same hand or foot due to the same Covered Accident.

Accidental Impairment Benefit

We will pay an Accidental Impairment Benefit if you or your Dependent meet all of the following requirements:

- As a result of a Covered Accident suffer one of the following impairments:
  - Uniplegia
  - Hemiplegia
  - Triplegia
  - Paraplegia
  - Quadriplegia
  - Loss Of Hearing (in one or both ears)
  - Loss Of Sight (in one or both eyes)
- The impairment occurs within 365 days of the Covered Accident.

In the event you or your Dependent suffer more than one impairment as a result of the same Covered Accident, we will pay the stated percentage for each impairment as shown in the Table Of Accident Insurance Benefit Amounts in the **Coverage Features**, not to exceed 100% of the Accidental Death Benefit amount.

Hemiplegia means the complete and irreversible loss of function or total paralysis of the upper and lower Limbs on the same side of the body as confirmed by a Physician who is a board certified neurologist.

Loss Of Hearing means an entire, uncorrectable and irrecoverable loss of hearing in one or both ears, as diagnosed by a Physician who is a board certified Otolaryngologist.

Loss Of Sight means entire, uncorrectable and irrecoverable loss of sight in one or both eyes, as diagnosed by a Physician who is a board certified Ophthalmologist.

Paraplegia means the complete and irreversible loss of function or total paralysis of both lower Limbs confirmed by a Physician who is a board certified neurologist.

Quadriplegia means the complete and irreversible loss of function or total paralysis of both upper and lower Limbs confirmed by a Physician who is a board certified neurologist.

Triplegia means the complete and irreversible loss of function or total paralysis of three Limbs, or the complete and irreversible loss of function or total paralysis of two Limbs and the face confirmed by a Physician who is a board certified neurologist.

Uniplegia means the complete and irreversible loss of function or total paralysis of one Limb confirmed by a Physician who is a board certified neurologist.

Value Added AD&D Benefits

Air Bag Benefit

We will pay an Air Bag Benefit if you or your Dependent meet all of the following requirements:

- Travel in an Automobile involved in a Covered Accident and for which an Accidental Death Benefit and Seat Belt Benefit is payable for the same Covered Accident.
- The Automobile is equipped with an Air Bag System that was installed as original equipment by the Automobile manufacturer.
- Seated in the driver's or a passenger's seating position intended to be protected by the Air Bag System and the respective Air Bag System deployed in the crash as evidenced by a police accident report.
- The driver of the Automobile in which you or your Dependent were riding has a current and valid driver's license at the time of the Covered Accident.

Air Bag System means an automatically inflatable passive restraint system that is designed to provide automatic crash protection in front or side impact Automobile accidents and meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration.

Common Carrier Accidental Death Benefit

We will pay a Common Carrier Accidental Death Benefit if you or your Dependent meet all of the following requirements:

- A Covered Accident occurs while riding as a fare-paying passenger on a Common Carrier and for which an Accidental Death Benefit is payable for the same Covered Accident.
- The death occurs within 365 days after the Covered Accident.

The Common Carrier benefit may be paid in addition to the Accidental Death Benefit.

Common Carrier means a licensed commercial airplane, train, bus, trolley, subway, ferry or boat that charges a fare and operates on a regularly scheduled basis between predetermined points or cities. Taxis and privately chartered airplanes or vehicles are not common carriers.

Helmet Benefit

We will pay a Helmet Benefit if you or your Dependent meet all of the following requirements:

- A Covered Accident occurs while operating or riding a motorcycle or bicycle and for which an Accidental Death Benefit is payable for the same Covered Accident.
- Wearing a Helmet at the time of the Covered Accident as evidenced by a police accident report, medical examiner report, or coroner's report.
- The operator of the motorcycle has a current and valid driver's license at the time of the Accident.

Helmet means protective headgear that meets or exceeds the standards established by the Code of Federal Regulations (CFR) in Title 16 Part 1203, Snell Memorial Foundation Standard M-95 or M2000, the American National Standards Institute specification Z 90. 1, or the United States Department of Transportation's Federal Motor Vehicle Safety Standard No.218, as amended and updated.

Line Of Duty Benefit

We will pay a Line Of Duty Benefit if you or your Dependent meet all of the following requirements:

- An Accidental Death Benefit, Accidental Dismemberment Benefit, or Accidental Impairment Benefit is payable for the same Covered Accident.
- You or your Dependent are a Public Safety Officer.
- The Covered Accident occurs in the Line Of Duty.

We will pay a Line Of Duty Benefit once per Covered Accident per insured person.

Line Of Duty means any action which by rule, regulation, law, or condition of employment you or your Dependent are obligated or authorized to perform as a Public Safety Officer, in the course of controlling or reducing crime, criminal law enforcement, or fire suppression, including such action taken in response to an emergency while off duty. Line Of Duty does not include non-emergency travel between the Public Safety Officer's residence and authorized work areas.

If you or your Dependent are a Public Safety Officer, whose primary job duties are controlling or reducing crime, criminal law enforcement, or fire suppression, Line Of Duty includes any one or more of the following: on duty at social, ceremonial, or athletic functions to which you or your Dependent are assigned or for which you are paid as a Public Safety Officer by your Employer, or your Dependent is paid as a Public Safety Officer by their employer, or going directly to, attending, or returning directly from meetings or conventions associated with your or your Dependent's profession.

Public Safety Officer means an individual whose primary job duties include controlling or reducing crime or juvenile delinquency, criminal law enforcement, or fire suppression. Public Safety Officer includes any one or more of the following: police officers, firefighters, corrections officers, probation officers, public transit officers, parole officers, judicial officers, and officially recognized or designated volunteer firefighters, if they otherwise meet the definition of Public Safety Officer.

Repatriation Benefit

We will pay a Repatriation Benefit if you or your Dependent meet all of the following requirements:

- As a result of a Covered Accident an Accidental Death Benefit is payable.
- Death occurs more than 100 miles from the primary place of residence.
- Expenses are incurred to transport the remains to a mortuary.

Seat Belt Benefit

We will pay a Seat Belt Benefit if you or your Dependent meet all of the following requirements:

- Travel in an Automobile involved in a Covered Accident and for which an Accidental Death Benefit is payable for the same Covered Accident.
- Wearing and properly utilizing a Seat Belt System or restrained in a Child Safety Seat at the time of the Covered Accident, as evidenced by a police accident report.
- The driver of the Automobile in which you or your Dependent were riding has a current and valid driver's license at the time of the Covered Accident.

Child Safety Seat means a removable seat designed to hold a Child while riding in an Automobile and that attaches to a standard seat with hooks or straps that meets the Federal Motor Vehicle Safety Standards of the National Highway Traffic Safety Administration. Child Safety Seat includes: rear-facing, forward facing, and booster seats.

Seat Belt System means a properly installed combination lap and shoulder restraint system that meets the Federal Motor Vehicle Safety Standards of the National Highway Traffic Safety Administration. Seat Belt System will include a lap belt alone, but only if the Automobile did not have a combination lap and shoulder restraint system when manufactured. Seat Belt System does not include a shoulder restraint alone.

EXCLUSIONS

Benefits are not payable if the Accident is proximately caused by any of the following:

- War or act of War. War means declared or undeclared war, whether civil or international.
- Suicide or other intentionally self-inflicted Injury while sane or insane.
- Committing or attempting to commit a felony or being engaged in an illegal occupation.

- Any Accident sustained or contracted in consequence of you or your Dependent being intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician.
- Sickness existing at the time of the Accident, including any medical or surgical treatment or diagnostic procedure for a Sickness.
- Travel or flight in or on any aircraft, except:
    - As a fare-paying passenger on a regularly scheduled commercial flight.
    - As a passenger or pilot in the Policyholder's or Employer's aircraft while flying on the Policyholder's or Employer's business provided:
        - The aircraft has a valid U.S. airworthiness certificate (or foreign equivalent).
        - The pilot has a valid pilot's certificate with a non-student rating authorizing him or her to fly the aircraft.
- Engaging in mountain biking, caving, heli-sking, boxing, full contact martial arts, bungee jumping, parachuting, base jumping, skydiving, hang gliding, sail gliding, parasailing, parakiting, kitesurfing, kiteboarding or scuba diving.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Routine eye exams and dental procedures other than a crown or extraction for a tooth or teeth as a result of a Covered Accident.
- Riding in or driving any automobile in a race, stunt show, or speed test.
- Surgery or other procedure which is directed at improving your or your Dependent's appearance, unless such surgery or procedure is necessary to correct a deformity or restore bodily function resulting from a Covered Accident.
- Any Accident which occurs while you or your Dependents are incarcerated in a jail, penal, or correctional institution.

ADDITIONAL FEATURES

Reinstatement

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

- If your insurance ends because you cease to be a Member and if you become a Member again within 90 day(s), the Eligibility Waiting Period will be waived.
- If you ceased to be a Member under the Group Policy and continued insurance under the **Continuation of Insurance (Portability) for the Member** provision and you become a Member again within 90 day(s), your insurance will be for the coverages and amount which you continued under the **Continuation of Insurance (Portability) for the Member** provision on the day before you become a new Member.

In no event will insurance be retroactive.

Continuity of Coverage

Waiver of **Active Work Requirement**

If you were insured under the Prior Plan on the day before the effective date of the Employer's coverage under the Group Policy, you can become insured on the effective date of your Employer's coverage without meeting the **Active Work Requirement**. See the **Active Work Requirement**.

Continuation of Insurance (Portability) for the Member

Eligibility for the Member:

You become eligible to continue your or your Dependent's insurance on the date one of the following events occurs:

- Your employment terminates with your Employer.
- The Group Policy terminates.
- Your insurance ends because you are no longer a Member.

You are not eligible to continue insurance under this provision if:

- You are disabled.
- You are age 80 or older.

Application, Amount of Insurance, and Premium Payment

You must apply in writing and pay the first premium to us within 31 days after the date you become eligible. Your and your Dependent's continued insurance will be the same insurance amounts provided under the Group Policy on the day before you become eligible under this **Continuation of Insurance (Portability) for the Member** provision. You may decrease insurance amounts, but cannot increase the insurance amounts.

You will be directly billed for all premiums due if you have applied for and been approved for continuation of insurance under this provision. If premium is not paid on or before the Premium Due Date stated below it may be paid during the Grace Period stated below. Your and your Dependent's insurance will remain in force during the Grace Period. You are liable for premium for insurance during the Grace Period.

The Premium Due Date is the first day of each calendar month.

The Grace Period is 60 days from the Premium Due Date.

When Insurance Ends

Insurance continued under this provision ends automatically on the earliest of:

- The date the last period ends for which you made the premium payment.
- The date you die.
- The date you become a full-time member of the armed forces of any country.
- With respect to your Child's insurance, the date the Child ceases to meet the definition of Child.
- The date you reach age 80.
- The date you are sentenced by a court for any reason to a penal or correctional institution.
- With respect to your Spouse insurance, the date the Spouse ceases to meet the definition of Spouse.
- With respect to insurance for your Spouse or Child, the date your Spouse or Child is sentenced by a court for any reason to a penal or correctional institution.
- The date you become insured again as a Member under the Group Policy.

Once insurance continued under this provision ends it cannot be reinstated. Except as provided above, insurance continued under this provision is subject to all other terms of the Group Policy.

CLAIMS

Notice of Claim

Written notice of claim must be provided to us within 60 days after the date of an Accident or within 60 days after meeting the requirements for an Accident Insurance Benefit, or as soon thereafter as is reasonably possible.

Filing a Claim

Claims should be filed on our forms upon receipt of written notice of claim. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us. The letter should include the nature and extent benefits are being claimed as required in the **Proof Of Loss** provision. Subject to the time period in the **Notice of Claim** provision, such letter will constitute notice.

Time Limits on Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of meeting the requirements for an Accident Insurance Benefit. Failure to provide such proof within the required time limits shall not invalidate nor reduce any claim if the Proof Of Loss is provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the Member or Beneficiary lacks legal capacity.

Proof Of Loss

Proof Of Loss means written proof regarding the occurrence, the character, and the extent of a Covered Accident:

- For which the Group Policy provides benefits.
- Which is not subject to any exclusions.
- Which meets all other conditions for benefits.

Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be paid until we receive Proof Of Loss.

Investigation of Claim

We reserve the right and opportunity during the pendency of a claim to examine the person of any of individual whose Accident is the basis of the claim, at our expense. In case of death, at our expense, we have the right and opportunity to request an autopsy, except where prohibited by law.

Notice of Decision on Claim

We will evaluate a claim for benefits promptly after we receive it. Within 60 days after we receive the claim we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 60 days.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension, and (b) when we expect to decide the claim.

If we deny any part of the claim, we will send the claimant a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- A description of any additional information needed to support the claim.
- Information concerning the claimant's right to a review of our decision.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial of the claim.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. With respect to all claims, within 45 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension and (b) when we expect to decide the claim on review.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

If we deny any part of the claim on review, the claimant will receive a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

Time of Payment

We will pay benefits immediately after Proof Of Loss is satisfied.

Reimbursement

We reserve the right to recover any benefits that you, your Dependent, a claimant or beneficiary were paid but not entitled to under the terms of the Group Policy, state, or federal law.

You, your Dependent, a claimant, or beneficiary must reimburse us in full. We will determine the method by which repayment is to be paid.

Unpaid Premium

Any unpaid premium due for your or your Dependent’s insurance under the Group Policy may be recovered by us. Any Accident Insurance Benefits payable to you, your Dependent, a claimant, a beneficiary, or legal representative will be applied to reduce the amount of any unpaid premiums prior to paying you, your Dependent, a claimant, a beneficiary, or a legal representative.

BENEFIT PAYMENT AND BENEFICIARY PROVISIONS

Payment of Benefits

Accident Insurance Benefits payable because of your death will be paid to the Beneficiary you name. See **Naming a Beneficiary, Simultaneous Death Provision,** and **No Surviving Beneficiary** provisions below.

Accident Insurance Benefits payable because of the death of your Dependent will be paid to you if you are living. Accident Insurance Benefits payable because of the death of your Dependent which are unpaid at your death will be paid to your named Beneficiary.

Except for the Repatriation Benefit, all other Accident Insurance Benefits will be paid to you. Any such benefits remaining unpaid at your death will be paid according to the **Naming a Beneficiary, Simultaneous Death Provision,** and **No Surviving Beneficiary** provisions for payment of a death benefit due to your death. The Repatriation Benefit will be paid to the person who incurs the transportation expense.

Naming a Beneficiary

Beneficiary means a person you name to receive death benefits.

If you name two or more Beneficiaries in a class:

- Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
- If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

You may name or change Beneficiaries at any time without the consent of a Beneficiary.

Any payment we make according to the Beneficiary designation on file with the Policyholder or Employer or their or our designated agents will fully discharge us to the extent of the payment for each line of coverage and each death benefit which has been paid.

You may name or change Beneficiaries in writing. Writing includes a form signed by you or a verification from us, or our designated agent, the Policyholder's designated agent, the Employer, or the Employer's designated agent of an electronic designation made by you.

Your designation must satisfy all of the following:

- Be dated.
- Be delivered to us, our designated agent, the Policyholder, the Policyholder's designated agent, the Employer, or the Employer's designated agent during your lifetime.
- Relate to the insurance provided under the Group Policy.

The designation will take effect on the date it is delivered or, if an electronic designation, verified by us, our designated agent, the Policyholder, the Policyholder's designed agent, the Employer, or the Employer's designated agent.

If we approve it, a designation which meets the requirements of a Prior Plan will be accepted as your Beneficiary designation under the Group Policy.

Simultaneous Death Provision

If a Beneficiary or a person in one of the classes in the **No Surviving Beneficiary** provision dies on the same day you or your Spouse die, or within 15 days thereafter, benefits will be paid as if that Beneficiary or person had died before you, unless Proof Of Loss with respect to your death is delivered to us before the date of the Beneficiary's death.

No Surviving Beneficiary

If you do not name a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class below.

- Your Spouse.
- Your children.
- Your parents.
- Your brothers and sisters.
- Your estate.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy may not be assigned.

Time Limits on Legal Actions

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought after the expiration of three years after the date Proof Of Loss is required to be given.

Incontestability of Insurance

Any statement made to obtain insurance or to increase insurance is a representation and not a warranty.

After insurance has been in effect for three years during the lifetime of the insured, we will not use a misstatement made in an application by you to reduce or deny the claim, unless it was a fraudulent misstatement.

Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

- Cause a person to become insured.
- Invalidate insurance under the Group Policy otherwise validly in force.
- Continue insurance under the Group Policy otherwise validly terminated.

Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of us. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

Misstatement of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct age.

- The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

DEFINITIONS

Accident or Accidental

An Injury sustained by you or your Dependent as a result of an event or occurrence that was not reasonably foreseen or that you or your Dependent could not have reasonably expected or anticipated.

Admitted

A stay at a Hospital or Critical Care Unit for at least 20 consecutive hours for examination by a Physician for diagnosis or treatment of a Covered Accident.

Ambulance (Ground or Air)

A licensed professional ground or air ambulance company to transport you or your Dependent to a Hospital or a Health Service Facility for diagnosis or treatment of a Covered Accident.

Ambulatory Surgical Center

A licensed facility that is mainly engaged in performing Outpatient surgery. An Ambulatory Surgical Center must:

- Be staffed by Physicians and nurses under the supervision of a Physician.
- Have permanent operating and recovery rooms.
- Be capable of administering anaesthesia by a licensed anaesthesiologist or licensed nurse anaesthetist.
- Be staffed and equipped to give emergency care.
- Have written back-up arrangements with a local Hospital for emergency care.

Automobile

A private passenger motor vehicle licensed for use on public roads and highways.

Calendar Year

The period from January 1 through December 31 of the same year.

Child

Child means one of the following:

- Your child from live birth until age 26.
- Your adopted child or a child placed with you for adoption until age 26.
- Your stepchild, foster child, dependent grandchild, and the child of your Spouse if living in your home until age 26.
- A child living in your home for whom you are the court appointed legal guardian until age 26.
- Your child, stepchild, foster child, dependent grandchild, and the child of your Spouse who is continuously incapable of self-sustaining employment because of mental or physical handicap; and chiefly dependent upon you for support and maintenance or institutionalized because of mental or physical handicap.

Child does not include a person who is eligible for insurance as a Member. A Child does not include a full-time member of the armed forces of any country.

Confinement or Confined

You or your Dependent are Admitted to a Hospital or Critical Care Unit, or admitted to a Rehabilitation Facility, as an Inpatient for diagnosis and treatment of a Covered Accident for a period of no less than 20 consecutive hours the first day and overnight for subsequent days. Hours spent in an emergency room immediately prior to being Admitted to a Hospital will count toward the required 20 consecutive hours.

Covered Accident

An Accident that occurs on or after you or your Dependent are insured under the Group Policy and is not excluded by name or specific description.

Critical Care Unit (CCU)

Critical Care Unit (CCU) means a specified area within a Hospital that is restricted to patients who are critically ill or injured and require intensive comprehensive observation and care. This area must:

- Be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
- Be permanently equipped with special lifesaving equipment for the care of the critically ill or injured.
- Be under close observation by a specially trained nursing staff assigned exclusively to the unit on a 24-hour basis.
- Have a Physician assigned on a full-time basis.

Dependent(s)

Your Spouse or Child.

Eligibility Waiting Period

The period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the Coverage Features.

Emergency Room

A specified area within a Hospital that is staffed and equipped for emergency patient care. This area must:

- Be supervised with treatment provided by Physicians.
- Provide care seven days per week, 24 hours per day.

Employer

An employer (including approved affiliates and subsidiaries) coverage under the Group Policy is approved in writing by us.

Group Policy

The Group Accident Insurance Policy issued by us to the Policyholder and identified by the Group Policy Number, the Policyholder's attached application, Group Accident Insurance Certificate with the same Group Policy Number, and any amendments to the policy or certificates.

Health Care Provider

A Physician, Nurse Practitioner, or Physician Assistant.

Health Service Facility or Facilities

Health Service Facility or Facilities means one of the following:

- A Rehabilitation Facility.
- A nursing or convalescent home.
- A long term nursing unit or geriatrics ward.

- A skilled nursing facility.
- An Ambulatory Surgical Center.
- An Urgent Care Facility.
- An assisted living facility.
- A hospice care facility.
- Health Care Provider office or clinic.

Hospital

A legally operated facility providing full-time medical care and treatment under the direction of a full-time staff of licensed Physicians. Hospital does not include Health Service Facilities.

Initial Care

The first visit for Outpatient medical services. Initial Care does not include visits for wellness, annual physicals, acupuncture, preventative treatment physical therapy, or for treatment for a chiropractic, allergy or immunotherapy, vision, speech, or hearing disorder.

Injury or Injuries

An injury to your or your Dependent's body.

Inpatient

A person who has been Admitted to a Hospital or Critical Care Unit, or admitted to a Rehabilitation Facility, as a registered bed patient for which a charge is incurred for room and board or observation.

Limb

The entire arm from shoulder to fingers, or the entire leg from hip to toes.

Mental Disorder

Any mental, emotional, behavioural, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders or anxiety and anxiety disorders.

Nurse Practitioner (advanced practice registered nurse)

An individual who is licensed by the state as a nurse practitioner to practice medicine under the supervision of a Physician and acting within the scope of the license. Nurse Practitioner does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Occupational Therapist

An individual who is licensed by the state to practice occupational therapy and performs the occupational services acting within the scope of the license. Occupational Therapist does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Outpatient

Treatment for which a stay is not required and no charge is incurred for room and board or observation.

Physician

A licensed medical professional, diagnosing and treating individuals within the scope of the license. The term includes a legally licensed physician, dentist, optometrist, podiatrist, psychologist, or chiropractor.

Physician Assistant

An individual who is licensed by the state as a physician assistant to practice medicine under the supervision of a Physician and acting within the scope of the license. Physician Assistant does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Physical Therapist

An individual who is a licensed physical therapist acting within the scope of the license. Physical Therapist does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Pregnancy

Your or your Dependent's pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan

An accident insurance plan which is replaced by coverage under the Group Policy and which is the Policyholder's group accident insurance plan in effect on the day before the effective date of the Group Policy.

Rehabilitation Facility

A licensed facility that provides skilled care, intermediate care, intermingled care, custodial care or rehabilitation care services on an Inpatient basis as an alternative to a Hospital. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable a patient disabled by an Accident to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians.

A Rehabilitation Facility does not include:

- A nursing or convalescent home.
- A rest home for the aged.
- A hospice care facility.
- An assisted living facility.
- Chemical dependency treatment facility.
- Mental health treatment facility.

Sickness

Your or your Dependent's illness, mental or physical disease that produces structural or functional changes in the body, independent of an Injury. Sickness includes Mental Disorder, Pregnancy, and Substance Abuse.

Speech Therapist

An individual who is licensed by the state as a speech-language pathologist and acting within the scope of the license. Speech Therapist does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Spouse

Spouse means:

- A person to whom you are legally married.
- A person who is party to a Civil Union with you. Civil Union means a civil union established according to applicable law.
- Your Domestic Partner. Domestic Partner means an individual recognized as such under California state law.

Spouse does not include a full-time member of the armed forces of any country.

Substance Abuse

Being intoxicated by alcohol or under the influence of any controlled substance unless administered on the advice of a Physician.

Urgent Care Facility

A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short term urgent medical care, without an appointment.

ERISA INFORMATION AND NOTICE OF RIGHTS

Statement of Your Rights under ERISA

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Right to Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

Right to Obtain Copies of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

Right to Receive a Copy of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

Right to Review of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

Obligations of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Plan and ERISA Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N. W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.