RELIANCE STANDARD
LIFE INSURANCE COMPANY

Home Office: Schaumburg, Illinois • Administrative Office: Philadelphia, Pennsylvania

POLICYHOLDER: United Cerebral Palsy Association of Greater Cleveland, Inc. **POLICY NUMBER:** VAI 825941

EFFECTIVE DATE: May 1, 2017

ANNIVERSARY DATES: May 1, 2018 and each May 1st thereafter.

PREMIUM DUE DATES: The first premium is due on the Effective Date. Further premiums are due monthly, in advance, on the first day of each month.

This Policy is delivered in Ohio and is governed by its laws and/or the Employee Retirement Income Security Act of 1974 ("ERISA") as amended, where applicable.

This insurance Policy is a contract between you, the Policyholder named above, and us, Reliance Standard Life Insurance Company. We agree to provide insurance to you in exchange for the payment of premium and the signed Application. This Policy insures against certain accidental losses as described herein. It will cover the Eligible Persons for whom the proper premium has been paid for the Benefit Amounts shown on the Schedule of Benefits. Coverage is subject to the terms and conditions of this Policy. In the event of a conflict between this Policy and the Certificate, the terms of this Policy control.

The Effective Date of this Policy is shown above. Insurance starts and ends at 12:01 A.M., local time, at your address. It stays in force in accordance with the provisions set forth in this Policy. The "POLICY TERMINATION" section of the GENERAL PROVISIONS explains when this Policy can be ended.

This Policy is signed by our President and Secretary.

Secretary

President

READ THIS POLICY CAREFULLY. THIS POLICY PROVIDES LIMITED BENEFITS. THIS POLICY IS NOT A MEDICAL INSURANCE POLICY.

THIS POLICY IS OPTIONALLY RENEWABLE.

GROUP ACCIDENT POLICY
NON-PARTICIPATING

APPLICATION FOR GROUP ACCIDENT POLICY

RELIANCE STANDARD LIFE INSURANCE COMPANY
PHILADELPHIA, PENNSYLVANIA

GROUP POLICY NUMBER: VAI 825941 **POLICY EFFECTIVE DATE:** May 1, 2017

POLICY DELIVERED IN: Ohio **ANNIVESARY DATE:** May 1st in each year

APPLICATION IS MADE TO US BY: United Cerebral Palsy Association of Greater Cleveland, Inc.

This Application is completed in duplicate, one copy is attached to your Policy and the other is to be returned to us.

It is agreed that this Application takes the place of any previous application for your Policy.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signed at:_____ This:_____ Day of:_____

Policyholder: _____

Federal Employer Identification Number: 34-0753561

By: _____
(Signature)

_____
(Title)

Please sign and return.

*BC1COAPVAI 82594105/01/2017*RSL
*BC2COAPUnited Cerebral Palsy Association of Greater Cleveland, Inc.

APPLICATION FOR GROUP ACCIDENT POLICY

RELIANCE STANDARD LIFE INSURANCE COMPANY
PHILADELPHIA, PENNSYLVANIA

GROUP POLICY NUMBER: VAI 825941 **POLICY EFFECTIVE DATE:** May 1, 2017

POLICY DELIVERED IN: Ohio **ANNIVESARY DATE:** May 1st in each year

APPLICATION IS MADE TO US BY: United Cerebral Palsy Association of Greater Cleveland, Inc.

This Application is completed in duplicate, one copy is attached to your Policy and the other is to be returned to us.

It is agreed that this Application takes the place of any previous application for your Policy.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signed at:_____ This:_____ Day of:_____

Policyholder: _____

Federal Employer Identification Number: 34-0753561

By: _____
(Signature)

_____
(Title)

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

NAME OF SUBSIDIARIES, DIVISIONS OR AFFILIATES TO BE COVERED: NONE

ELIGIBILITY: Each active, Full-time employee, except any person employed on a temporary or seasonal basis.

SERVICE WAITING PERIOD:

Exempt* Employees:	30 days of continuous employment.
Non-exempt* Employees:	60 days of continuous employment.

* as defined by the Fair Labor Standards Act, as amended.

INDIVIDUAL EFFECTIVE DATE: The first day of the month coinciding with or next following the date an Eligible Person completes his/her enrollment form.

INDIVIDUAL REINSTATEMENT: 6 months

MINIMUM PARTICIPATION REQUIREMENTS: Number of Insureds: 10

COVERAGE TYPE: On and Off-the-Job (24 hour coverage)

The employee and spouse must be under age 70 to enroll for insurance coverage.

CHANGES IN BENEFIT AMOUNTS: Increases in the Benefit Amounts for any reason are effective on the Policy Anniversary Date coinciding with or next following the date of the change, provided the Insured is Actively at Work on the effective date of the change. If the Insured is not Actively at Work when the change would otherwise take effect, the change will take effect on the day after the Insured has returned to Active Work for one (1) full day.

Decreases in the Benefit Amounts are effective on the Policy Anniversary Date coinciding with or next following the date of the change.

CONTRIBUTIONS:	Each Eligible Person:	100%
	Each Eligible Person and Dependent spouse:	100%
	Each Eligible Person and Dependent child(ren):	100%
	Each Eligible Person and Dependents:	100%

Receipt of benefits under this Policy may be taxable. It is recommended that the Insured contact his/her personal tax advisor.

BENEFIT AMOUNTS: Eligible for Plan A, B or C

EMERGENCY CARE BENEFITS:

Type of Benefit	PLAN A Benefit Amount	PLAN B Benefit Amount	PLAN C Benefit Amount
Air Ambulance Transportation	$500	$750	$1,000
Ambulance Transportation	$100	$150	$200
Emergency Treatment	$150	$200	$250
Diagnostic Examination	$100	$200	$400
Initial Physician Office Visit	$50	$75	$100

GENERAL TREATMENT BENEFITS:

Type of Benefit	Benefit Amount	Benefit Amount	Benefit Amount
Initial Hospital Admission	$500	$1,000	$1,500
Initial Intensive Care Unit (ICU) Hospital Admission	$1,000	$1,500	$2,250
Hospital Confinement	$200 per day	$250 per day	$350 per day
Intensive Care Unit (ICU) Confinement	$400 per day	$500 per day	$700 per day
Rehabilitation Facility Confinement	$50 per day	$100 per day	$150 per day
Follow-up Physician Office Visit	$50	$75	$100
Transportation	$300	$450	$600
Lodging	$100 per day	$150 per day	$200 per day

SPECIFIED COVERED INJURY AND TREATMENT BENEFITS:

Type of Benefit	PLAN A Benefit Amount		PLAN B Benefit Amount		PLAN C Benefit Amount	
Fractures:	**Surgical**	**Non-Surgical**	**Surgical**	**Non-Surgical**	**Surgical**	**Non-Surgical**
Ankle	$600	$300	$900	$450	$1,200	$600
Arm	$600	$300	$900	$450	$1,200	$600
Bones of Face	$300	$150	$450	$225	$600	$300
Coccyx	$300	$150	$450	$225	$600	$300
Collarbone	$600	$300	$900	$450	$1,200	$600
Elbow	$600	$300	$900	$450	$1,200	$600
Finger	$100	$50	$150	$75	$200	$100
Foot	$600	$300	$900	$450	$1,200	$600
Hand	$600	$300	$900	$450	$1,200	$600
Hip	$3,200	$1,600	$4,800	$2,400	$6,400	$3,200
Kneecap	$600	$300	$900	$450	$1,200	$600
Leg	$1,600	$800	$2,400	$1,200	$3,200	$1,600
Jaw	$600	$300	$900	$450	$1,200	$600
Nose	$300	$150	$450	$225	$600	$300
Pelvis	$1,600	$800	$2,400	$1,200	$3,200	$1,600
Rib	$300	$150	$450	$225	$600	$300
Shoulder Blade	$600	$300	$900	$450	$1,200	$600
Skull (Except bones of face or nose – Depressed)	$5,000	$2,500	$7,500	$3,750	$10,000	$5,000
Skull (Simple)	$1,500	$750	$2,250	$1,125	$3,000	$1,500
Sternum	$600	$300	$900	$450	$1,200	$600
Toe	$100	$50	$150	$75	$200	$100
Vertebrae	$600	$300	$900	$450	$1,200	$600
Vertebral Column	$1,600	$800	$2,400	$1,200	$3,200	$1,600
Wrist	$600	$300	$900	$450	$1,200	$600
Chip Fractures	25% of Benefit Amount for non-surgical full fracture					
Multiple Fractures	100% of the highest Benefit Amount for any one fracture among all fractures sustained					
Dislocations:						
Ankle	$1,200	$600	$1,800	$900	$2,400	$1,200
Collarbone	$1,200	$600	$1,800	$900	$2,400	$1,200
Elbow	$600	$300	$900	$450	$1,200	$600
Finger	$200	$100	$300	$150	$400	$200
Foot	$1,200	$600	$1,800	$900	$2,400	$1,200
Hand	$600	$300	$900	$450	$1,200	$600
Hip	$3,200	$1,600	$4,800	$2,400	$6,400	$3,200
Knee	$2,000	$1,000	$3,000	$1,500	$4,000	$2,000
Lower Jaw	$600	$300	$900	$450	$1,200	$600
Shoulder	$600	$300	$900	$450	$1,200	$600
Toe	$200	$100	$300	$150	$400	$200
Wrist	$600	$300	$900	$450	$1,200	$600
Partial Dislocation	25% of Benefit Amount for non-surgical full dislocation					
Multiple Dislocations	100% of the highest Benefit Amount for any one dislocation among all dislocations sustained					

Type of Benefit	PLAN A Benefit Amount	PLAN B Benefit Amount	PLAN C Benefit Amount
Blood, Plasma and Platelets:	$200	$300	$400
Burns:			
2nd Degree Burns			
Covering less than 10% of the body	$100	$200	$400
Covering 10% but less than 25% of the body	$200	$400	$800
Covering 25% but less than 35% of the body	$400	$800	$1,600
Covering 35% (or greater) of the body	$800	$1,600	$3,200
3rd Degree Burns			
Covering less than 10% of the body	$800	$1,600	$3,200
Covering 10% but less than 25% of the body	$1,600	$3,200	$6,400
Covering 25% but less than 35% of the body	$3,200	$6,400	$12,800
Covering 35% (or greater) of the body	$6,400	$12,800	$25,600
Skin Grafts (due to Burns)	25% of the Benefit Amount payable for Burns		
Coma:	$5,000	$7,500	$10,000
Concussion:	$100	$150	$200
Dental Injury:			
Extraction	$50	$75	$100
Crown	$150	$300	$400
Eye Injury:			
Removal of Foreign Object	$100	$150	$200
Surgical Repair	$200	$300	$400
Lacerations:			
No Sutures Required	$25	$35	$50
Sutures Required (Total length of all sutured Lacerations):			
Less than 2” long	$50	$75	$100
2” but less than 6” long	$200	$300	$400
6” long or greater	$400	$600	$800
PARALYSIS BENEFITS:			
Paraplegia or Hemiplegia	$5,000	$7,500	$10,000
Quadriplegia	$10,000	$15,000	$20,000

Type of Benefit	PLAN A Benefit Amount	PLAN B Benefit Amount	PLAN C Benefit Amount
SURGERY BENEFITS:			
Exploratory Surgery (No Repair)	$100	$150	$200
Knee Cartilage (Surgically Repaired)	$300	$450	$800
Abdominal or Thoracic Surgery (Surgically Repaired)	$1,000	$1,500	$2,000
Ruptured Disc (Surgically Repaired)	$500	$750	$1,000
Tendon, Ligament or Rotator Cuff (Surgically Repaired):			
One Repair:	$300	$450	$750
Two or more Repairs:	$600	$900	$1,500
TRANSITIONAL BENEFITS:			
Medical Appliance	$100	$150	$200
Prosthesis:			
One:	$500	$750	$1,000
Two or more:	$1,000	$1,500	$2,000
Physical Therapy (per session)	$25	$35	$50
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:			
Loss of Life:			
Employee	$25,000	$50,000	$100,000
Spouse	$12,500	$25,000	$50,000
Child(ren)	$5,000 per child	$10,000 per child	$20,000 per child
Loss of Life on a Common Carrier:	100% of Loss of Life	100% of Loss of Life	100% of Loss of Life
Loss of one of the following: Hand, Foot, Arm, Leg, Sight in One Eye, Hearing in One Ear	50% of Loss of Life	50% of Loss of Life	50% of Loss of Life
Loss of finger, thumb or toe:			
One Loss	$250	$500	$500
Two or more Losses	$750	$1,500	$1,500
Catastrophic Loss as follows: Speech, Two or more Losses, except the Loss of fingers, thumbs or toes	100% of Loss of Life	100% of Loss of Life	100% of Loss of Life

For Insureds age 65 and over, the Benefit Amount for Accidental Death and Dismemberment, Common Carrier and Catastrophic Loss Benefits is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Benefit Amount will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 65 or over on their Individual Effective Date.

Age	**Percentage of available or in force amount at age 64**
65-69	50%
70+	25%

The Dependent spouse Benefit Amount for Accidental Death and Dismemberment, Common Carrier and Catastrophic Loss Benefits will reduce in the same manner as the Insured's Benefit amount upon the Dependent spouse's attainment of the reducing age(s).

Child Benefit Amounts will not reduce.

DEFINITIONS

"Actively at Work" and "Active Work" means the Insured is actually performing on a Full-time basis each and every duty pertaining to his job working for you in the place where and the manner in which the job is normally performed. This includes approved time off for vacation, jury duty and funeral leave, but does not include time off as a result of injury or sickness.

"Burns" means:

(1) 2nd degree burns, which are those that have burned through the first layer of skin as well as the second layer of skin (dermis); and
(2) 3rd degree burns, which are those that have burned through all layers of the skin and causes permanent tissue damage; and

cover a specific percentage of the body as shown on the Schedule of Benefits.

"Catastrophic Loss" means two or more Losses, as defined, excluding the Loss of a finger, thumb or toe or any combination thereof. Loss of speech is considered catastrophic without an accompanying Loss.

"Coma" means a state of profound unconsciousness, from which one cannot be aroused, that lasts continuously for at least a period of one hundred sixty-eight (168) hours requiring confinement in a Hospital under the care of a Physician, board certified as a neurologist. The Physician's diagnosis must be supported by a Glasgow Coma Scale score of no greater than seven (7) or a score of Level V or less on the Rancho Los Amigos Scale throughout the one hundred sixty-eight (168) hour period and an abnormal Electroencephalogram (EEG).

"Common Carrier" means any:

(1) aircraft operated under a license for hire for the transportation of passengers; or
(2) land conveyance licensed for hire for the transportation of passengers.

"Concussion" means a blow to the head that results in loss of consciousness, confusion, loss of memory or generally being dazed.

"Covered Accident" means an accident or event that:

(1) could not have been foreseen, anticipated or expected;
(2) occurs while the Insured's or Insured Dependent's coverage is in force under this Policy;
(3) occurs on or off the job;
(4) results in Injury for which benefits may be payable; and
(5) is not excluded under the terms of this Policy.

"Dentist" means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which such license was issued.

"Dependents" means:

(1) the Insured's legal spouse; and
(2) the Insured's child(ren), from birth to 26 years, including natural children, legally adopted children, children who are dependent on the Insured during the waiting period before adoption, stepchildren, and foster children. Foster children must be in the Insured's custody to be considered a Dependent; and
(3) the Insured's child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on the Insured for support and maintenance.

"Dislocation" means complete displacement of a bone from its normal articulation with a joint, also called luxation. Partial Dislocation is an incomplete displacement of a bone from its normal articulation with a joint, also called subluxation.

"Eligible Person" means a person who meets the Eligibility Requirements of this Policy.

"Fracture" means a bone that is broken which is diagnosed by a Physician. A Chip Fracture means that a fragment of bone has been broken off.

"Full-time" means working for you for a minimum of 20 hours during a person's regularly scheduled work week.

"Glasgow Coma Scale" means a system for assessing the severity of brain impairment in an individual with a brain injury that uses the sum of scores given for eye-opening, verbal, and motor responses. A high score of fifteen (15) indicates no impairment and a score of seven (7) or less indicates severe impairment.

"Hospital" means a legally operated, accredited facility licensed to provide full-time care and treatment for the condition for which benefits are payable under this Policy. It is operated with a full-time staff of Physicians and registered nurses. It does not include facilities that primarily provide custodial or rehabilitative care, education, or long-term institutional care on a residential basis.

"Hospital Confinement/Confined" means that the Insured or Insured Dependent has been formally admitted to a Hospital on the advice of a Physician and remains in the Hospital more than twenty-three (23) hours.

"Immediate Family" means the parents, siblings, spouse or children of the Insured or Insured Dependent.

"Injury" means bodily injury to the Insured or Insured Dependent resulting directly from an accident independent of all other causes, which occurs while such Insured's or Insured Dependent's coverage under this Policy is in force.

"Inpatient" means that the Insured or Insured Dependent has been admitted to a Hospital on the advice of a Physician and remains in the Hospital more than twenty-three (23) hours.

"Insured" means a person employed by the Policyholder who meets the Eligibility Requirements of this Policy and is enrolled for this insurance.

"Insured Dependent" means a "Dependent", as defined, whose insurance under this Policy is in effect.

"Intensive Care Unit (ICU)" means a specific area of the Hospital, set apart from the surgical recovery room and other rooms used for confinement of patients, providing:

(1) intensive medical care and treatment to only those patients who are in critical condition;
(2) continuous observation of and care to patients by a specially trained nursing staff that is dedicated exclusively to the ICU on a twenty-four (24) hour basis;
(3) a Physician assigned exclusively to the ICU on a full-time basis; and
(4) life-saving equipment required to treat patients in critical condition which is permanently located in the ICU.

"Loss" as used in the Dismemberment and Catastrophic Loss benefits, means severance or total and irrecoverable loss of:

(1) the hand or foot through or above the wrist or ankle joint;
(2) the arm above the elbow;
(3) the leg above the knee;
(4) a finger, thumb or toe, including at least one joint, which is either partially or completely severed;
(5) sight in an eye in which the corrective visual acuity is worse than 20/200 or the field of vision is 20 degrees or less;
(6) hearing that cannot be corrected to any degree by any procedure or device; or
(7) speech which cannot be corrected to any degree by any procedure or device,

which results directly and independently from an Injury with no other contributing cause.

"Medical Appliance" means an appliance that assists the Insured or the Insured Dependent with mobility such as crutches, wheel chairs, or walkers.

"Medical Professional" means a person, other than a Physician, that provides medical care and services within the scope of his or her license such as physician's assistants, nurse practitioners and registered nurses.

"Outpatient" means an Insured or Insured Dependent who receives medical care, treatment and services when not confined in a Hospital on an Inpatient basis.

"Paralysis" means Paraplegia, Quadriplegia or Hemiplegia diagnosed by a Physician and as defined below:

(1) "Paraplegia" means complete and permanent loss of motor function of both lower limbs.
(2) "Quadriplegia" means complete and permanent loss of motor function of both the upper and lower limbs.
(3) "Hemiplegia" means complete and permanent loss of motor function of the upper and lower limbs of the same side of the body.

"Physician" means a duly licensed medical or osteopathic doctor who is recognized by the law of the state in which treatment is provided as qualified to treat the type of Injury for which claim is made. The Physician may not be the Insured or a member of his/her Immediate Family.

"Ranchos Los Amigos Scale" means a system used by the medical profession for measuring levels of awareness, cognition, behavior and interaction with the environment. A score of Level VII means no impairment and a Level V or less indicates severe impairment.

"Rehabilitation Facility" means any facility or Hospital that is licensed in the state in which it is operating to provide rehabilitation services, therapy or retraining to the Insured or Insured Dependent to enable him or her to walk, communicate, and/or function as a member of society.

"Therapist" means an individual:

(1) licensed to practice physical or occupational therapy in the state in which therapy is provided; and
(2) providing services within the scope of his or her license.

"We", "us", and "our" means Reliance Standard Life Insurance Company.

"You", "your", and "yours" means the Policyholder.

CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER

For the purposes of this Policy, you as the Policyholder, act on your behalf or as the employee's agent. Under no circumstances will you be deemed our agent.

Compliance With Americans With Disabilities Act (ADA)

It is your responsibility to establish and maintain procedures which comply with the employer responsibilities of the Americans With Disabilities Act of 1990, as amended.

Compliance With The Employee Retirement Income Security Act (ERISA)

It is your responsibility to establish and maintain procedures which comply with the employer and/or Plan Administrator responsibilities of ERISA and the accompanying regulations, where applicable.

Distribution Of Certificates Of Insurance

Certificates of Insurance will be provided to you for Insureds covered under this Policy. The Certificate will outline the insurance coverage, and explain the provisions, benefits and limitations of this Policy. It is your responsibility to distribute the appropriate Certificates and any updates or other notices from us to each Insured.

Maintenance Of Records

It is your responsibility to maintain sufficient records of each Insured's insurance, including additions, terminations and changes. We reserve the right to examine these records at the place where they are kept during normal business hours or at a place mutually agreeable to you and us. Such records must be maintained by you for at least three (3) years after this Policy terminates.

Reporting Of Eligibility And Coverage Amounts

It is your responsibility to notify us on a timely basis of all individuals eligible for coverage under this Policy, of all individuals whose eligibility for coverage ends and of all changes in individual coverage amounts.

It is your responsibility to provide accurate census information on all Insureds on or before each Anniversary Date, if we request such information.

Timely Payment Of Premiums

It is your responsibility to pay all premiums required under this Policy when due. Any change in the premium contribution basis must be approved by us.

Premium Rate Changes

It is your responsibility to provide advance notice to Insureds in the event of any applicable rate change that would impact their premium contribution.

GENERAL PROVISIONS

ENTIRE CONTRACT: The entire contract between you and us is this Policy, your signed Application for this Policy (a copy of which is attached at issue), and any endorsements or amendments, and the individual applications.

CHANGES: No agent has the authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, signed by a President, Vice President or Secretary and attached to this Policy.

INCONTESTABILITY: Any statement made in your application will be deemed a representation, not a warranty. We cannot contest this Policy after it has been in force for two (2) years from the date of issue, except for non-payment of premium.

Any statements made by you, any Insured or any Insured Dependent, or on behalf of any Insured or any Insured Dependent to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the Benefit Amount for which an Insured or any Insured Dependent is covered. The following rules apply to each statement:

(1) No statement will be used in a contest unless:

   (a) it is in a written form signed by the Insured or any Insured Dependent, or on behalf of any Insured or any Insured Dependent; and

   (b) a copy of such written instrument is or has been furnished to the Insured or any Insured Dependent, the Insured's or any Insured Dependent's beneficiary, or legal representative.

(2) If the statement relates to an Insured's or any Insured Dependent's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two (2) years during the lifetime of the Insured or any Insured Dependent. Also, we will not use such statements to contest a benefit increase after such benefit increase has been in force for two (2) years during the Insured's or any Insured Dependent's lifetime.

ASSIGNMENT: The benefits under this Policy may not be assigned, except as required by law.

RECORDS MAINTAINED: You or an authorized Plan Administrator must maintain records of all Insureds. Such records must show the essential data of the insurance, including new persons, terminations, changes, etc. This information must be reported to us regularly. We reserve the right to examine the insurance records maintained at the place where they are kept. This review will only take place during normal business hours.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by you, us, or the Plan Administrator:

(1) will not terminate insurance that would otherwise have been effective; and

(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

MISSTATEMENT OF AGE: If an Insured's or Insured Dependent spouse's age has been misstated, benefits will be those that apply to his/her correct age.

NOT IN LIEU OF WORKERS' COMPENSATION: This Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

CONFORMITY WITH STATE LAWS: Any provision in this Policy which, on its Effective Date, is in conflict with the laws in the state where it is issued or in a state that otherwise has jurisdiction over such provision, is amended to conform with the minimum requirements of such laws of that state.

CERTIFICATE OF INSURANCE: Certificates of insurance will be provided to you for Insureds covered under this Policy. The certificate will outline the insurance coverage and to whom benefits are payable.

POLICY TERMINATION: You may cancel this Policy at any time. This Policy will be cancelled on the date we receive your letter or, if later, the date requested in your letter.

We may cancel this Policy:

(1) if the premium is not paid at the end of the grace period; or
(2) if the number of Insureds (excluding Dependents) covered is less than the Minimum Participation Number on the Schedule of Benefits; or
(3) on any Policy Anniversary after coverage has been in force for twelve (12) months.

If we cancel because of (1) above, this Policy will be cancelled at the end of the grace period. If we cancel because of (2) or (3) above, we will give you thirty-one (31) days written notice prior to the date of cancellation.

You will still owe us any premium that is not paid up to the date this Policy is cancelled. We will return any part of the premium paid beyond the date this Policy is cancelled.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

GENERAL GROUP: The general group will be your employees and employees of any subsidiaries, divisions or affiliates named on the Schedule of Benefits.

ELIGIBLE CLASSES: The eligible classes will be those persons described on the Schedule of Benefits.

ELIGIBILITY REQUIREMENTS: A person is eligible for insurance under this Policy if he/she:
(1) is a member of an Eligible Class, as shown on the Schedule of Benefits page; and
(2) has completed the Service Waiting Period, as shown on the Schedule of Benefits page.

SERVICE WAITING PERIOD: A person who is continuously employed on a Full-time basis with you for the period specified on the Schedule of Benefits has satisfied the Service Waiting Period.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If you pay the entire premium, the insurance of an Eligible Person will go into effect on the date stated on the Schedule of Benefits. If an Eligible Person pays a part of the premium, he/she must apply in writing for the insurance to go into effect. He/she will become insured on the later of:

(1) the Individual Effective Date as shown on the Schedule of Benefits; or
(2) the first day of the month coinciding with or next following the date he/she applies; or
(3) the date premium is remitted.

Changes in the Insured Benefit Amount are effective as shown on the Schedule of Benefits.

If an Eligible Person is not Actively At Work on the day his/her insurance is to go into effect, the insurance will go into effect on the day he/she returns to Active Work for one full day.

TERMINATION OF INDIVIDUAL INSURANCE: An Insured's coverage will terminate on the first of the following to occur:

(1) the date this Policy terminates;
(2) the date the Insured ceases to be in a class eligible for this insurance;
(3) the end of the period for which premium has been paid; or
(4) the date the Insured enters military service (not including Reserves or National Guard).

Any Loss which occurs prior to the termination of this insurance coverage will not be affected.

CONTINUATION OF INDIVIDUAL INSURANCE: The insurance of the Insured and any Insured Dependents may be continued, by payment of premium, beyond the date the Insured ceases to be eligible for this insurance, but not longer than:

(1) twelve (12) months, if due to sickness or Injury; or
(2) one (1) month, if due to temporary lay-off or approved leave of absence.

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if a former Insured has been:
(1) on an approved leave of absence; or
(2) on temporary lay-off.

The former Insured must return to Active Work with you within the period of time shown on the Schedule of Benefits. He/she must also be a member of a class eligible for this insurance.

The former Insured will not be required to fulfill the Eligibility Requirements of this Policy again. The insurance will go into effect on the date he/she returns to Active Work. However, if the former Insured returns after having resigned or having been discharged, he/she will be required to fulfill the Eligibility Requirements of this Policy again.

BENEFIT PROVISIONS

We will pay one or more of the following benefits as listed under Emergency Care Benefits, General Treatment Benefits, Specified Covered Injury and Treatment Benefits, Paralysis Benefits, Surgery Benefits, Transitional Benefits and Accidental Death and Dismemberment Benefits if the Insured or Insured Dependent sustains an Injury due to a Covered Accident and meets all of the requirements defined for payment under a specific benefit. Please refer to the Schedule of Benefits for benefit amounts payable.

EMERGENCY CARE BENEFITS:

Air Ambulance Transportation: An Air Ambulance Transportation benefit will be payable should the Insured or Insured Dependent sustain an Injury as a result of a Covered Accident if:

(1) a licensed ambulance company provides air transport:
    (a) to or from a Hospital; or
    (b) between medical facilities; and
(2) the air ambulance transportation is provided within forty-eight (48) hours of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident. This benefit may be payable in addition to an Ambulance Transportation benefit.

Ambulance Transportation: An Ambulance Transportation benefit will be payable should the Insured or Insured Dependent sustain an Injury as a result of a Covered Accident if:

(1) a licensed ambulance company provides ground transport:
    (a) to or from a Hospital; or
    (b) between medical facilities; and
(2) ground transportation is provided within ninety (90) days of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident. This benefit may be payable in addition to an Air Ambulance Transportation benefit.

Emergency Treatment: An Emergency Treatment benefit will be payable should the Insured or Insured Dependent sustain an Injury as a result of a Covered Accident if:

(1) he or she is examined or treated in a Hospital emergency room or urgent care facility; and
(2) emergency treatment is received within seventy-two (72) hours of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Diagnostic Examination: A Diagnostic Examination benefit will be payable if the Insured or Insured Dependent must undergo one of the following diagnostic examinations as prescribed by a Physician due to Injury sustained as a result of a Covered Accident:

(1) Computed Tomography (CT or CAT) scan;
(2) Magnetic Resonance Imaging (MRI);
(3) Positron Emission Tomography (PET) scan; or
(4) Single Photon Emission Computed Tomography (SPECT) scan.

Such examination must be performed within sixty (60) days of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Initial Physician Office Visit: An Initial Physician Office Visit benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident and is examined or treated by a Physician or Medical Professional in such individual's office. Examination or treatment must be provided within sixty (60) days of the Covered Accident.

This benefit is not payable if the Insured or Insured Dependent is eligible to receive a benefit under Emergency Treatment.

Only one (1) benefit will be paid for each person insured per Covered Accident.

GENERAL TREATMENT BENEFITS:

Initial Hospital Admission: An Initial Hospital Admission lump sum benefit will be payable if the Insured or Insured Dependent sustains an Injury due to a Covered Accident and requires admission to a Hospital if:

(1) admission occurs within one hundred eighty (180) days of the Covered Accident; and
(2) the Hospital stay is more than twenty-three (23) hours; and
(3) it is the first Hospital admission for such Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

This benefit will not be payable if:

(1) treatment is given in the emergency room; or
(2) treatment is provided on an Outpatient basis.

If a benefit is payable under the Initial Hospital Admission benefit as well as under the Initial Intensive Care Unit (ICU) Hospital Admission benefit, only one (1) benefit will be paid, which is the highest.

The Insured or Insured Dependent may also be eligible for a Hospital Confinement benefit.

Initial Intensive Care Unit (ICU) Hospital Admission: An Initial ICU Hospital Admission lump sum benefit will be payable if the Insured or Insured Dependent sustains an Injury due to a Covered Accident and requires admission to the ICU of a Hospital if:

(1) admission occurs within one hundred eighty (180) days of the Covered Accident;
(2) the ICU stay is more than twenty-three (23) hours; and
(3) it is the first ICU admission for such Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

If a benefit is payable under the Initial Intensive Care Unit (ICU) Hospital Admission benefit as well as under the Initial Hospital Admission benefit, only one (1) benefit will be paid, which is the highest.

The Insured or Insured Dependent may also be eligible for an Intensive Care Unit (ICU) Confinement benefit.

Hospital Confinement: A Hospital Confinement benefit will be payable for each day the Insured or Insured Dependent is confined in a Hospital because an Injury is sustained due to a Covered Accident if the initial confinement begins within one hundred eighty (180) days of the Covered Accident.

This benefit is payable per day for up to three hundred sixty-five (365) days for each person insured per Covered Accident over the course of three hundred sixty-five (365) days from the date of initial Hospital Confinement.

Only one (1) Hospital Confinement benefit is payable regardless of whether more than one Covered Accident caused such confinement.

If a Hospital Confinement benefit and an Intensive Care Unit (ICU) Confinement benefit are both payable on the same day, only the ICU Confinement benefit will be paid for that day. A Hospital Confinement benefit and an Intensive Care Unit (ICU) Confinement benefit may both be payable for one Hospital stay but are payable based on where the Insured or Insured Dependent is on any given day.

Intensive Care Unit (ICU) Confinement: An ICU Confinement benefit will be payable for each day the Insured or Insured Dependent is confined in the ICU of a Hospital because of an Injury sustained due to a Covered Accident if confinement begins within thirty (30) days of the Covered Accident.

This benefit will be payable for up to thirty (30) days for each person insured per Covered Accident over the course of three hundred sixty-five (365) days from the date of initial ICU confinement.

Only one (1) ICU Confinement benefit is payable regardless of whether more than one Covered Accident caused such confinement. If an ICU Confinement benefit and a Hospital Confinement benefit are both payable on the same day, only the ICU Confinement benefit will be paid for that day. An ICU Confinement benefit and a Hospital Confinement benefit may both be payable for one Hospital stay but are payable based on where the Insured or Insured Dependent is on any given day. If the Insured or Insured Dependent exhausts the ICU Confinement benefit before such confinement is over, a Hospital Confinement benefit may be payable.

Rehabilitation Facility Confinement: A Rehabilitation Facility Confinement benefit will be payable for each day the Insured or Insured Dependent is confined in a Rehabilitation Facility because of Injury sustained due to a Covered Accident if confinement begins within one hundred eighty (180) days of the Covered Accident.

This benefit is payable per day for up to thirty (30) days for each person insured per Covered Accident over the course of three hundred sixty-five (365) days from the date of initial Rehabilitation Facility Confinement.

Only one (1) Rehabilitation Facility Confinement benefit is payable regardless of whether more than one Covered Accident caused such confinement. The Rehabilitation Facility Confinement benefit is not payable for any day that the Insured or Insured Dependent receives benefits under the Hospital Confinement or ICU Confinement benefits.

Follow-up Physician Office Visit: A Follow-up Physician Office Visit benefit will be payable for follow-up examination or treatment by a Physician or Medical Professional in such individual's office if the Insured or Insured Dependent has sustained an Injury as a result of a Covered Accident. Examination or treatment must be provided within sixty (60) days of the Covered Accident.

This benefit is not payable while the Insured or Insured Dependent is confined in a Hospital, ICU or Rehabilitative Facility.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Transportation: A Transportation benefit will be payable should the Insured or Insured Dependent sustain an Injury due to a Covered Accident if:

(1) he or she must travel more than one hundred (100) miles one way for treatment at a Hospital or other medical facility;
(2) the treatment is prescribed by a Physician;
(3) the treatment is not available locally; and
(4) transportation is by bus, train, airplane or medical transportation vehicle.

This benefit is payable for up to three (3) round trips for treatment for each person insured per Covered Accident.

The Transportation benefit is not payable if transport is provided by ambulance or air ambulance.

Lodging: A Lodging benefit is payable for each day a friend, caregiver or family member travels more than one hundred (100) miles away from his or her home to support the Insured or Insured Dependent who is Hospital confined because of an Injury sustained due to a Covered Accident. The friend, caregiver or family member must temporarily reside in a hotel, motel or hospital-sponsored lodging. Lodging benefits will be payable for one (1) person.

This benefit is payable for up to thirty (30) days within three hundred sixty-five (365) days of the Covered Accident.

SPECIFIED COVERED INJURY AND TREATMENT BENEFITS:

Fracture: A Fracture benefit will be payable if the Insured or Insured Dependent sustains a Fracture or Chip Fracture as a result of a Covered Accident provided it is diagnosed by a Physician within ninety (90) days of the Covered Accident.

If the Insured or Insured Dependent sustains more than one (1) fracture as a result of such Covered Accident, we will pay one (1) benefit, which is the highest.

Dislocation: A Dislocation benefit will be payable if the Insured or Insured Dependent sustains a dislocation or partial dislocation as a result of a Covered Accident provided it is diagnosed by a Physician within ninety (90) days of the Covered Accident.

If the Insured or Insured Dependent sustains more than one (1) dislocation as a result of such Covered Accident, we will pay one (1) benefit, which is the highest.

Blood, Plasma and Platelets: A Blood, Plasma and Platelet benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident requiring a transfusion of blood, plasma or platelets provided such transfusion is administered within ninety (90) days of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Burns: A Burn benefit will be payable if the Insured or Insured Dependent sustains a 2nd or 3rd degree burn as a result of a Covered Accident provided treatment is received from a Physician within seventy-two (72) hours of the Covered Accident.

If the Insured or Insured Dependent sustains Burns in more than one (1) classification as shown on the Schedule of Benefits, only one (1) Burn benefit, which is the highest, will be paid for each person insured per Covered Accident.

Skin Graft (due to Burns): A Skin Graft benefit will be payable if the Insured or Insured Dependent requires skin grafting as a result of a Burn sustained in a Covered Accident and was paid a benefit under the Burn benefit.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Coma: A Coma benefit will be payable if the Insured or Insured Dependent is in a Coma, as diagnosed by a Physician, for one hundred sixty-eight (168) hours as a result of a Covered Accident. However, benefits will not be paid when a Coma has been medically induced.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Concussion: A Concussion benefit will be payable if the Insured or Insured Dependent sustains a Concussion as a result of a Covered Accident provided it is diagnosed by a Physician within seventy-two (72) hours of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Dental Injury: A Dental Injury benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident to his or her natural teeth which requires:

(1) extraction; or
(2) repair by insertion of a crown.

Initial treatment must be provided by a Dentist within seven (7) days of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Eye Injury: An Eye Injury benefit will be payable if the Insured or Insured Dependent sustains an Injury to his or her eye or eyes as a result of a Covered Accident provided a Physician:

(1) performs surgical repair on the eye or eyes within ninety (90) days of a Covered Accident; or
(2) removes a foreign object from the eye or eyes within ninety (90) days of the Covered Accident.

Only one (1) benefit will be paid for each eye for each person insured per Covered Accident.

Lacerations: A Laceration benefit will be payable if the Insured or Insured Dependent is Injured as a result of a Covered Accident and sustains a laceration (cut), provided it is treated by a Physician or Medical Professional within seventy-two (72) hours of the Covered Accident.

This benefit is payable:
(1) once for the total number of lacerations received not requiring sutures (stitches); and
(2) once for the total length of all lacerations received requiring sutures,

for each person insured as a result of any one (1) Covered Accident.

If a laceration would normally require sutures but the Physician or Medical Professional chooses to repair the laceration by some other medically accepted method, the benefit will still be payable as if the repair was made with sutures.

PARALYSIS BENEFITS:

Paralysis: A Paralysis benefit will be payable if the Insured or Insured Dependent sustains an Injury due to a Covered Accident that results in Paralysis if:

(1) the Insured or Insured Dependent loses the function of two or more limbs for an uninterrupted period of sixty (60) days; and
(2) such Paralysis is confirmed by a Physician.

The uninterrupted sixty (60) day period of Paralysis is waived if clinical and radiological evidence shows that the spinal cord has been transected with no possibility of returned functionality.

SURGERY BENEFITS:

Exploratory Surgery: An Exploratory Surgery benefit will be payable for exploratory surgery for the procedures listed under Surgery Benefits if such surgery is performed and no repair is done.

Only one (1) benefit will be payable for each person insured per Covered Accident.

Knee Cartilage: A Knee Cartilage benefit will be payable if the Insured or Insured Dependent sustains torn cartilage in the knee due to a Covered Accident if the Injury is:

(1) treated by a Physician within seventy-two (72) hours of the Covered Accident; and
(2) repaired or removed through surgery by a Physician within three hundred sixty-five (365) days of the Covered Accident.

Only one (1) benefit will be payable per knee for each person insured per Covered Accident.

Abdominal or Thoracic Surgery: An Abdominal or Thoracic Surgery benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident that is diagnosed as requiring abdominal or thoracic surgery and is, indeed, surgically treated by a Physician within seventy-two (72) hours of the Covered Accident.

Only one (1) benefit will be payable for each person insured per Covered Accident.

Ruptured Disc: A Ruptured Disc benefit will be payable if the Insured or Insured Dependent sustains a ruptured disc in the spine as a result of a Covered Accident requiring surgical repair if the Injury is:

(1) treated by a Physician within sixty (60) days of the Covered Accident; and
(2) repaired surgically by a Physician within three hundred sixty-five (365) days of the Covered Accident.

Only one (1) benefit will be payable for each person insured per Covered Accident.

Tendon, Ligament, Rotator Cuff: A Tendon, Ligament, Rotator Cuff benefit will be payable if the Insured or Insured Dependent sustains an Injury to tendons, ligaments or rotator cuffs as a result of a Covered Accident requiring surgical repair if the Injury is:

(1) treated by a Physician within sixty (60) days of the Covered Accident; and
(2) repaired surgically by a Physician within one hundred eighty (180) days of the Covered Accident.

This benefit will be payable for up to two (2) surgically repaired tendons, ligaments or rotator cuffs, or any combination thereof, for each person insured per Covered Accident.

TRANSITIONAL BENEFITS:

Medical Appliance: A Medical Appliance benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident which requires a Medical Appliance to assist him or her with mobility provided such appliance is prescribed by a Physician or Medical Professional and received by the Insured or Insured Dependent within three hundred sixty-five (365) days of the Covered Accident.

If the Injury sustained is considered a Catastrophic Loss as defined, the Medical Appliance must be prescribed by a Physician or Medical Professional and received by the Insured or Insured Dependent within two (2) years of the Covered Accident.

Only one (1) benefit is payable for each person insured per Covered Accident.

Prosthesis: A Prosthesis benefit will be payable if the Insured or Insured Dependent requires a prosthetic limb as a result of Injury sustained due to a Covered Accident if such prosthesis is prescribed by a Physician and received by the Insured or Insured Dependent within three hundred sixty-five (365) days of the Covered Accident.

If the Injury sustained is considered a Catastrophic Loss as defined, a Physician must prescribe the prosthesis and the Insured or Insured Dependent must receive it within two (2) years of the Covered Accident.

Only one (1) benefit is payable per limb, up to two (2) limbs, for each person insured per Covered Accident.

Physical Therapy: A Physical Therapy benefit will be payable should the Insured or Insured Dependent sustain an Injury as a result of a Covered Accident which requires therapy if it:

(1) is prescribed by a Physician;
(2) is provided by a Therapist;
(3) is performed in an office, Hospital or Rehabilitation Facility on an Inpatient or Outpatient basis;
(4) begins within ninety (90) days of the Covered Accident; and
(5) is completed within three hundred sixty-five (365) days of the Covered Accident.

This benefit is payable for up to six (6) therapy sessions for each person insured per Covered Accident.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:

Accidental Death and Dismemberment: An Accidental Death and/or Dismemberment benefit will be payable in accordance with the Schedule of Benefits if the Insured or Insured Dependent sustains an Injury due to a Covered Accident that results in death or dismemberment Loss, if death or dismemberment Loss occurs within three hundred sixty-five (365) days of the Covered Accident.

A Dismemberment benefit will be payable if a body part listed on the Schedule of Benefits as a Loss is surgically re-attached.

If a Catastrophic Loss benefit is payable for a Covered Accident, no benefit will be payable under this benefit for the same Loss.

Common Carrier: A Common Carrier benefit will be payable in addition to the Accidental Death Benefit if the Insured or Insured Dependent sustains an Injury due to a Covered Accident on a Common Carrier, as defined, which results in death within three hundred sixty-five (365) days of the Covered Accident.

Catastrophic Loss: A Catastrophic Loss benefit will be payable if the Insured or Insured Dependent sustains an Injury due to a Covered Accident that results in a Catastrophic Loss if such Loss occurs within three hundred sixty-five (365) days of the Covered Accident. The benefit payable is shown on the Schedule of Benefits.

If a Catastrophic Loss benefit is payable for a Covered Accident, no benefit will be payable under the Accidental Dismemberment benefit for the same Loss. The total benefit payable under this benefit cannot exceed that of the Accidental Death benefit.

DEPENDENT INSURANCE

Nothing in this section will change or affect any of the terms of this Policy other than as specifically set out in this section. All the Policy provisions not in conflict with these provisions shall apply to this section.

When an Insured Dependent sustains an Injury due to a Covered Accident we will pay the applicable benefit shown on the Schedule of Benefits. Only dependents that meet the definition of Dependent can be insured for this benefit.

Any benefit payable for an Insured Dependent will be paid to the Insured unless another individual has been designated as beneficiary.

A person may not have coverage under this Policy both as an Insured and as an Insured Dependent. Only one eligible spouse may cover the eligible children as Insured Dependents. Dependents may be covered as Insured Dependents if not covered as an Insured. If insurance is in force for an Insured Dependent child, any newly eligible Dependent child(ren) will be automatically covered.

ELIGIBILITY: An Eligible Person is eligible to enroll his/her eligible Dependents on the date he/she becomes an Insured.

EFFECTIVE DATE OF DEPENDENT INSURANCE: If you pay the entire premium for Dependents, a Dependent's insurance will become effective on the later of:

(1) the first day of the month coinciding with or next following the date the Insured becomes eligible for Dependent Insurance; or
(2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent.

If you require an Insured to pay a portion of the Dependent premium for Dependent insurance, he/she may insure his/her Dependents by making written application. In this case, the insurance for Dependents will take effect on the later of:

(1) the first day of the month coinciding with or next following the date the Insured becomes eligible for Dependent insurance; or
(2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent, if application is made on or before that date; or
(3) the first day of the month coinciding with or next following the date of application; or
(4) the date the premium applicable to the coverage selected is remitted.

Changes in the Insured Dependent's Benefit Amount are effective as shown on the Schedule of Benefits.

TERMINATION OF DEPENDENT INSURANCE: The insurance for an Insured Dependent will terminate on the first of the following dates:

(1) the date this Section terminates;
(2) the end of the period for which premium for Dependent insurance has been paid;
(3) the date the Insured's insurance terminates; or
(4) the date the dependent is no longer a Dependent as defined.

NEWLYWED PROVISION: At the marriage of an Insured who had not previously elected Dependent spouse coverage, his/her new spouse shall automatically become an Insured Dependent spouse.

Such spouse shall be an Insured Dependent spouse for thirty-one (31) days. He/she shall then cease to be an Insured Dependent spouse unless:

(1) the Insured requests, in writing and within such thirty-one (31) day period, continuation of such Dependent spouse coverage; and
(2) the additional premium is paid for such coverage.

NEWBORN CHILDREN: If a child is born to an Insured who has not elected Dependent child(ren) coverage, such child shall be an Insured Dependent child from the moment of birth.

The newborn child shall be an Insured Dependent child for thirty-one (31) days. He/she shall then cease to be an Insured Dependent child unless:

(1) the Insured requests, in writing and within such thirty-one (31) day period, continuation of such Dependent child(ren) coverage; and
(2) the additional premium is paid for such coverage.

The above coverage will also be extended to newly adoptive, foster or stepchildren, as of the date they become financially dependent on an Insured for support, provided they otherwise meet the definition of a Dependent.

EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue the Insured's coverage and that of any Insured Dependent, if applicable, in accordance with your policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

(1) the premium for such Insured and his/her Dependents, if applicable, continues to be paid during the leave; and
(2) you have approved the Insured's leave in writing and provide a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

(1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
(2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue the Insured's coverage and that of any Insured Dependents, if applicable, in accordance with your policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured and his or her Dependents, if applicable, continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

This Policy, while coverage is being continued under this Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While the Insured is on a Family and Medical Leave of Absence for any reason other than his or her own illness or injury, or Military Services Leave of Absence, he or she will be considered Actively at Work. Any changes such as revisions to coverage due to change in class will apply during the leave except that increases in the Benefit Amount, whether automatic or subject to election, will not be effective for an Insured who is not considered Actively at Work until the Insured has returned to Active Work for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in this Policy.

The Insured's coverage and that of any Insured Dependent's, if applicable, will cease under this extension on the earliest of:

(1) the date this Policy terminates; or
(2) the end of the period for which premium has been paid for the Insured and Insured Dependent, if applicable; or
(3) the date such leave should end in accordance with your policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should you choose not to continue the Insured's coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, the Insured's coverage as well as any Dependent coverage, if applicable, will be reinstated in accordance with the Family and Medical Leave of Absence and USERRA.

PREMIUMS

PREMIUM PAYMENT: All premiums are to be paid by you to us, or to an authorized agent, on or before the due date. The premium due dates are stated on the face page of this Policy.

PREMIUM RATE: The premium for this insurance is based on the plan and coverage selected:

(1) Eligible Person Only
(2) Eligible Person and Dependent spouse
(3) Eligible Person and Dependent child(ren)
(4) Eligible Person and Dependents

We reserve the right to adjust the premium rate on any premium due date:

(1) after coverage has been in force for twenty-four (24) months; or
(2) if the coverage is changed by amendment.

We will not change the premium rate more than once in any twelve (12) month period unless the coverage is changed. We will notify you in writing at least thirty-one (31) days before a premium change is made due to (1) above.

GRACE PERIOD: You may pay the premium up to thirty-one (31) days after the date it is due. This Policy stays in force during this time. If the premium is not paid during the grace period, this Policy will be cancelled at the end of the grace period. You will still owe us the premium up to the date this Policy is cancelled.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: If the Insured dies, any death benefit payable and any other accrued benefits will be paid to the beneficiary named in records maintained by you. A beneficiary designation will be effective as of the date the Insured signed it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

The Insured will be the beneficiary of any benefit payable at the death of an Insured Dependent, unless another beneficiary has been named and placed on file as required.

The Insured can change the beneficiary by telling us in writing on our form. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received and approved by us or an authorized Plan Administrator. We cannot attest to the validity of such a change.

If an Insured's beneficiary dies at the same time as the Insured, or within fifteen (15) days after his/her death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise in another provision of this Policy.

If the Insured has not named a beneficiary, or an Insured's named beneficiary is not surviving at the Insured's death, any benefits due shall be paid to the first of the following classes to survive the Insured:

(1) the Insured's legal spouse;
(2) the Insured's surviving children (including legally adopted children), in equal shares;
(3) the Insured's surviving parents, in equal shares;
(4) the Insured's surviving siblings, in equal shares; or, if none of the above,
(5) the Insured's estate.

We will not be liable for any payment we have made in good faith.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed $1,000.

If the Insured has not named a beneficiary or the beneficiary is not surviving at the Insured's death, we may pay up to $2,500 of the benefit to the person(s) who, in our opinion, has incurred expenses in connection with the Insured's last illness, death or burial. Payment may also be made to the executor or administrator of the Insured's estate, or to any relative of the Insured by blood or marriage.

The balance of the benefit, if any, will be held by us, until an individual or representative:

(1) is validly named; or
(2) is appointed to receive the proceeds; and
(3) can give valid release to us.

With respect to the Facility of Payment provision, the benefit will be held with interest at a rate set by us.

We will not be liable for any payment we have made in good faith.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after the service or event occurs for which claim may be made, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name or Insured Dependent's name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within fifteen (15) days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the claim.

PROOF OF CLAIM: We must be given written proof of claim within ninety (90) days after the date of services or the occurrence of an event, or as soon as soon as reasonably possible thereafter. In any event, proof must be given within one (1) year, unless the claimant is legally incapable of doing so.

Proof of claims must include:

(1) the nature and date of the claim and reason claim is being made;
(2) a description of the event and/or services provided; and
(3) proof that the services or event occurred. Such proof may take the form of a receipt for services or some other official documentation supporting the claim and which is acceptable to us.

Within fifteen (15) days after receiving the first proof of claim, we may send a written acknowledgment. Such acknowledgment may request any missing information or other items we need in order to adjudicate the Insured's or Insured Dependent's claim. Such information or items we may request may include, but are not limited to:

(1) copies of x-rays or any other diagnostic tests performed;
(2) copies of medical records or charts; or
(3) any other information we may reasonably require.

TIME PAYMENT OF CLAIMS: When we receive written proof of claim, we will pay any benefits due. Benefits that provide for periodic payment will be paid accordingly.

PAYMENT OF CLAIMS: If an Insured dies, we will pay any death benefit and any other accrued benefits in accordance with the Beneficiary and Facility of Payment provisions. All other benefits will be paid to the Insured.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

COMPLAINT PROCEDURES: All complainants are encouraged to submit complaints in writing to the following address: Law Department, 2001 Market Street, Suite 1500, Philadelphia, PA 19103. All grievances will be fully investigated. We will notify complainants as to the progress of an investigation in a timely manner. A final determination will be made in writing by us not later than forty-five (45) calendar days after a grievance is submitted in writing unless we require an extension of time to obtain additional information to make a determination with respect to the subject of the grievance. The extension may not exceed forty-five (45) days from the end of the initial period unless the initial period is extended due to the complainant's failure to submit information necessary to decide the claim on appeal. If the extension is due to a complainant's failure to submit information, the period for making the determination shall be tolled until the date the complainant responds to the request for additional information. The final determination will be provided in writing and if appropriate in light of the response, will include a statement that the complainant has the right to a determination of the matter by the Commissioner or his or her designee.

PHYSICAL EXAMINATION AND AUTOPSY: At our own expense, we have the right to have the Insured or Insured Dependent examined as often as reasonably necessary when a claim is pending. We can also have an autopsy performed unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on this Policy within sixty (60) days after written proof of claim has been given as required by this Policy. No action may be brought after three (3) years (Kansas, five (5)

years; South Carolina, six (6) years) from the time written proof of claim is required to be submitted.

PORTABILITY

The Insured may continue the Group Accident insurance coverage under this Policy and that of his/her Insured Dependents if coverage would otherwise terminate because he/she ceases to be an Eligible Person, for reasons other than the termination of this Policy or the Insured's retirement provided he/she:

(1) notifies us in writing within thirty-one (31) days from the date he/she ceases to be eligible; and
(2) remits the necessary premiums when due; and
(3) has been covered for twelve (12) months under this Policy and/or the prior group accident insurance policy.

The Benefit Amount available under the Portability provision will be the current Benefit Amount the Insured and Insured Dependents are insured for under this Policy on the last day the Insured was Actively at Work.

The premium charged to continue coverage will be based on the prevailing rate charged to Insureds who choose to continue coverage under the Portability provision. Such premium will be billed directly to the Insured on a quarterly basis.

If an Insured's and Insured Dependents' Group Accident coverage under this Policy includes the Accidental Death and Dismemberment Benefit, then such benefits may be continued under this Policy.

Insurance coverage continued under this provision for the Insured or his/her Insured Dependents will terminate on the first of the following to occur:

(1) the end of the period for which premium has been paid; or
(2) the date the Insured reaches age seventy (70); or
(3) at any time coverage would normally terminate according to the terms of this Policy had the Insured continued to be an Eligible Person.

In addition, coverage will reduce at any time it would normally reduce according to the terms of this Policy had the Insured and Insured Dependent spouse continued to be eligible.

If this Policy terminates subsequent to the Insured's election to continue his/her coverage and that of his/her Insured Dependents, in accordance with the Portability provision, such coverage will be continued in accordance with the provisions of the Insured's certificate.

EXCLUSIONS

This Policy does not cover any loss:

(1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or

(2) caused by committing or attempting to commit suicide, while sane or insane, or intentionally self-inflicted injuries; or

(3) caused by or resulting from war or any act of war, declared or undeclared; or

(4) caused by or resulting from riding in, getting into or out of any aircraft, unless:

   (a) the Insured or Insured Dependent is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
   (b) the aircraft is not owned, leased or operated by or on behalf of you, the Insured or Insured Dependents, or any other employer of the Insured or Insured Dependents, unless a specific written agreement has been obtained from us; or

(5) sustained during the Insured's or Insured Dependent's commission or attempted commission of an assault or felony; or

(6) to which the Insured's or Insured Dependent's acute or chronic alcoholic intoxication is a contributing factor; or

(7) to which the Insured's or Insured Dependent's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.

RELIANCE STANDARD LIFE INSURANCE COMPANY

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

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

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

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

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

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

Ohio Department of Insurance
50 W. Town Street
Third Floor, Suite 300
Columbus, Ohio 43215

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

(please refer to next page)

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **not** provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

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

For more information about the Ohio Life & Health Insurance Guaranty Association, visit our website at:
www.olhiga.org