LifeMap Assurance Company
100 SW Market Street
P.O. Box 1271, MS E-3A
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

GROUP VOLUNTARY ACCIDENT ONLY INSURANCE CERTIFICATE OF COVERAGE

POLICYHOLDER: ASSOCIATED GENERAL CONTRACTORS HEALTH BENEFITS TRUST, OREGON COLUMBIA CHAPTER

POLICY NUMBER: OR 300267

REVISED EFFECTIVE DATE: FEBRUARY 1, 2014

This is to certify that LifeMap Assurance Company has issued and delivered the Group Voluntary Accident Only Policy to the Policyholder. The Policy insures the Employees of the Policyholder who are eligible for the insurance, become insured, and continue to be insured according to the terms of the Policy. The terms of the Policy that affect your insurance are contained in the following pages. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the Policy.

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This Certificate voids and replaces any prior Certificate issued under the Group Policy Number shown above.

This Certificate of Coverage describes the benefits that an insured Employee is entitled to receive and becomes a part of the Policy. **PLEASE READ THIS CERTIFICATE CAREFULLY**.

NOTICE TO BUYER:

1. **This is an accident-only policy.** This Policy does not pay benefits for a loss due to Illness. Review your policy carefully.
2. **This is a limited benefit policy.** This is not a Medicare Supplement Policy. It is not intended to cover all medical expenses.

The Coverage Outline on Page C-3 will tell you the classes of Employees eligible for insurance and when eligibility for insurance begins. The Schedule of Benefits on Page C-4 will tell you the amounts of insurance provided by the Policy. The Table of Contents on Page C-2 will help you find specific provisions. The Definitions section on Page C-8 will provide definitions of important terms used in this Certificate.

All terms of insurance under the Policy begin and end at 12:01 a.m. Standard time in the place where the Policy is delivered.

Signed for LifeMap Assurance Company at its Home Office in Portland, Oregon.

Secretary

President

This Policy does not cover accidents due to an Occupational Injury.

The Policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.

Non-Participating

TABLE OF CONTENTS

COVERAGE OUTLINE

Eligible Class: Eligibility is determined by each Participating Employer. Each Participating Employer may elect to base their eligibility on one of the following:

1.) All eligible Employees of Participating Employers; or

2.) All eligible Employees enrolled in the Employer-sponsored medical plan and working for the Participating Employer.

Employees must work a minimum of 17.5 hours per week on a regular basis.

Eligibility Waiting Period: The eligibility Waiting Period is determined by each Participating Employer. Waiting period options are; date of hire, 30 days, 60 days, 90 days, 120 days or 180 days of employment. Employees will become insured on the first of the month following the completion of the Waiting Period established by their Participating Employer.

Employee Contribution: Group Voluntary Accident Only Insurance is contributory. Premiums are paid by you through payroll deduction.

Continuation of Coverage under the Direct Bill Plan:

If you lose eligibility under the group, you may continue this coverage under the Direct Bill Plan. Your application to continue coverage under the Direct Bill Plan and payment of the first premium must be received in our Home Office within 31 days of the date your coverage ends under the Group Policy. See "Continuation of Coverage" on Page C-22 of this Certificate.

SCHEDULE OF BENEFITS

Unless otherwise specified, each benefit is payable a maximum of one time per Insured Person, per Covered Accident. Please see the Description of Benefits section for more detailed information concerning covered benefits and limitations.

BENEFIT	AMOUNT
Accident Emergency Treatment	$100
Accident Follow-up Visit	$50
Note: Maximum of four visits per Insured Person, per Covered Accident	
Accidental Death:	
Insured	$50,000
Spouse	$50,000
Child(ren)	$10,000
Accidental Death – Common Carrier:	
Insured	$200,000
Spouse	$200,000
Child(ren)	$20,000
Accidental Dismemberment:	
Loss of one or more digits	$2,000
Loss of one hand or one foot; or the loss or loss of use of one arm or leg; or the loss of sight of one eye; or the loss of hearing of both ears; or the loss of the ability to speak	$12,000
Loss or loss of use of both arms or both legs, or one arm and one leg; or the loss of both hands or both feet; or the loss of sight of both eyes; or any combination of two losses listed herein	$25,000
Loss or loss of use of both arms and both legs	$50,000
Note: Maximum of one accidental dismemberment benefit per Insured Person, per Covered Accident.	
Admission:	
Hospital Admission Benefit	$500
Intensive Care Unit Admission Benefit	$1,000
Note: The Hospital Admission Benefit and the Intensive Care Unit Admission Benefit will not both be payable for the same Covered Accident.	
Ambulance:	
Ground Ambulance Benefit	$200
Air Ambulance Benefit	$2,000

Appliance and Prosthetic Device:

Appliance Benefit (crutches, etc.)	$100
Prosthetic Device Benefit	$750 for one device $1,500 for two or more devices

Blood/Plasma/Platelets Administration $300

Burn:

2nd degree burns covering a total of at least 36% of the body surface	$1,000
3rd degree burns covering a total of:	
at least 9 but less than 18 square inches	$2,000
at least 18 but less than 35 square inches	$4,000
35 or more square inches	$12,000
Burn requiring skin graft	Additional 50% of the applicable burn benefit

Note: If the Insured Person receives burns of multiple degrees, we will pay the highest benefit; however, only one burn benefit is payable per Insured Person, per Covered Accident.

Coma $12,500

Complete Dislocation (Separated Joint):

	Closed Reduction	Open Reduction
Hip	$2,400	$4,800
Knee (except patella)	$1,200	$2,400
Ankle – bone/bones of the foot (other than toes)	$975	$1,950
Collarbone (sternoclavicular)	$600	$1,200
Lower jaw	$375	$750
Shoulder (glenohumeral);	$375	$750
Elbow	$375	$750
Wrist	$375	$750
Bone/bones of the hand (other than fingers)	$375	$750
Collarbone (acromioclavicular and separation)	$125	$250
One toe or finger	$125	$250

Concussion $75

Confinement:

Hospital Confinement Benefit	$100 per day, up to 365 days
Intensive Care Unit Confinement Benefit	$200 per day, up to 15 days
Rehabilitation Unit Confinement Benefit	$100 per day, up to 15 days

Note: The Hospital Confinement Benefit, Intensive Care Unit Confinement Benefit and Rehabilitation Unit Confinement Benefit cannot be paid concurrently.

Emergency Dental Work:

Broken tooth repaired with a crown, denture or implant	$400
Broken tooth resulting in extraction	$100

Eye Injury $300

Family Lodging $150 per night

Note: For one hotel room, up to 15 nights per Covered Accident, not to exceed the actual cost of the room.

Fracture

	Closed Reduction	**Open Reduction**
Skull (except bones of face or nose)		
Depressed skull fracture	$3,000	$6,000
Simple non- depressed skull fracture	$1,200	$2,400
Hip, thigh (femur)	$1,800	$3,600
Vertebrae, body of (excluding vertebral processes)	$900	$1,800
Pelvis (includes ilium, ischium, pubis, acetabulum, and acetabulum except coccyx)	$900	$1,800
Leg (tibia and/or fibula)	$900	$1,800
Bones of face or nose (except mandible or maxilla)	$450	$900
Upper jaw, maxilla (except alveolar process)	$450	$900
Upper arm between elbow and shoulder (humerus)	$450	$900
Lower jaw, mandible (except alveolar process)	$375	$750
Shoulder blade (scapula) and/or collarbone (clavicle, sternum)	$375	$750
Vertebral processes	$375	$750
Forearm (radius and/or ulna), hand, and/or wrist (except fingers)	$375	$750
Kneecap (patella)	$375	$750
Foot (except toes)	$375	$750
Ankle	$375	$750
Rib	$300	$600
Coccyx	$250	$500
Finger, toe	$125	$250

Imaging Study: $200

Note: One benefit per Insured Person, per Covered Accident.

Laceration (cut):

Laceration repaired by stitches when the total of all lacerations is:

less than 2 inches long	$75
at least 2 but less than 6 inches long	$250
is 6 inches or longer	$500
Laceration with no repair	$50

Physical or Occupational Therapy $35 per day

Note: Up to 10 benefit payments per Insured Person, per Covered Accident.

Surgery:

Cranial; Open Abdominal; Thoracic Surgery (other than hernia repair)	$1,500
Hernia repair	$150
Ruptured Disc with surgical repair	$750
Exploratory and Arthroscopic Surgery	$200
Knee Cartilage Torn – repair	$750
Tendon; Ligament or Rotator Cuff Surgery	$750 for one tendon, ligament or rotator cuff $1,500 for two or more

Transportation $600 per round trip

Note: Up to three benefits per Insured Person, per Covered Accident.

X-Ray $50

DEFINITIONS

Wherever used in this Policy, the following definitions will apply to the terms listed below. The masculine will include the feminine and the singular will include the plural.

"You" and **"your"** mean the Primary Insured. **"We," "us"** and **"our"** mean LifeMap Assurance Company.

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

Active Employment means the Employee is:

1. working for the Employer on a regular and active basis for at least the minimum number of hours stated in the Coverage Outline;
2. receiving regular earnings from the Employer; and
3. employed:
   a. at the Employer's usual place of business; or
   b. at a location to which the Employer's business requires the Employee to travel.

Accident means immediate physical damage to the body which:

1. results directly from an unexpected and unintentional event; and
2. is independent of disease, bodily infirmity or any other cause.

Application means the document pertaining to the plan of insurance applied for by the Policyholder. This document is attached to the Policy.

Beneficiary or **Beneficiaries** means the person or persons designated to receive the Accidental Death Insurance Proceeds.

Beneficiary Designation means the written instrument in which beneficiaries are named or changed. The Beneficiary Designation must be:

1. signed and dated by you; and
2. delivered to the Employer during your lifetime; and
3. in a form acceptable to us.

If the Policy replaces all or part of insurance provided by an earlier group policy through the same Employer, a Beneficiary Designation under the earlier policy may be accepted.

Calendar Year means the period from January 1 through December 31 of each year.

Certificate means a document prepared by us which sets forth:

1. the benefits to which the Insured Person is entitled;
2. the method by which we determine to whom benefits are payable; and
3. the conditions, limitations, exclusions and requirements that apply.

The Certificate is part of the Policy between the Policyholder and us.

Coma means a constant state of unconsciousness, which includes the absence of eye opening, motor response and verbal response, and which requires intubation for respiratory assistance.

Common Carrier means a commercial airplane, passenger train, bus, subway, trolley or boat that operates on a regular schedule. It does not include taxis and privately chartered vehicles.

Contributory Insurance means you must pay all or a part the premium for this coverage.

Covered Accident means an accident that:

1. occurs on or after the Policy Effective Date and while this Policy is in force;
2. is listed on the Schedule of Benefits; and
3. is not excluded by the Policy.

Dependent Child means your or your Spouse's "dependent" child who is under age 26, unmarried, and who meets any of the following criteria:

1. your or your Spouse's natural child, stepchild, adopted child, or child legally placed with you or your Spouse for adoption;
2. a child for whom you or your Spouse have court-appointed legal guardianship;
3. a child for whom you or your Spouse or are required to provide coverage by a legal qualified medical child support order (QMCSO).

Your or your Spouse's child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday will continue to be covered if you submit written evidence of the child's incapacity within 31 days of the later of the child's 26th birthday or your or your Spouse's Effective Date.

Domestic Partner (non-state certified)* means an adult of the same or opposite sex who has an emotional, physical and financial relationship with you, similar to that of a spouse, as evidenced by the following facts:

1. you and your domestic partner share a residence and financial responsibility for a joint household and intend to continue an exclusive relationship indefinitely;
2. you and your domestic partner each are at least eighteen (18) years of age;
3. you and your domestic partner are both mentally competent to enter into a binding contract;
4. neither you nor your domestic partner are married to or legally separated from anyone else;
5. you and your domestic partner are not related to one another by blood closer than would bar marriage; and
6. neither you nor your domestic partner is a domestic partner of anyone else.

***Participation of non-state certified Domestic Partners is determined by each Participating Employer.

Effective Date means the date specified by us, following our acceptance of the application for coverage, as the date coverage begins for you and/or your Enrolled Dependents.

Eligibility Waiting Period means the continuous length of time you must be Actively at Work before becoming eligible for coverage under the Policy. The Eligibility Waiting Period is determined by each Participating Employer.

Emergency Room means a designated area within a Hospital that provides emergency treatment of accidental Injuries or sicknesses. The Emergency Room must provide services under the supervision of staff Physicians; be staffed and equipped to handle trauma; and provide 24-hour a day services.

Employee means a person who:

1. is in Active Employment with the Employer;
2. is eligible for insurance according to the Outline of Coverage;
3. has federal taxes deducted from his or her earnings and has had FICA deducted, matched and remitted by the Employer;
4. is not a temporary, seasonal or contract Employee; and
5. is a citizen of the United States or legally works in the United States.

Employer/Participating Employer means an employer who has completed an application and has been accepted for coverage under the Associated General Contractors Health Benefits Trust, Oregon Columbia Chapter. This includes any division, subsidiary or affiliated company named in the Application for the Policy or any Policy amendments.

Enrolled Dependent means:

1. an Employee's eligible dependent who is listed on the Employee's application for coverage;
2. whose application is accepted by us; and
3. who is enrolled under this Policy.

Enrolled Employee means an Employee of the Policyholder who is eligible under the terms of the Policy, whose application we have accepted, and who is enrolled under this coverage.

Home Office means the principal office of LifeMap Assurance Company located at 100 SW Market St., MS E3A Portland, Oregon 97201**.**

Hospital means an institution which:

1. provides diagnostic and treatment facilities for inpatient surgical and medical care of persons who are injured or ill;
2. is licensed under the applicable laws as a general hospital;
3. provides services under the supervision of a staff physician; and
4. provides 24-hour a day nursing services by registered nurses.

The term "Hospital" as used herein does not include:

1. nursing home;
2. facilities providing primarily rehabilitation care;
3. assisted living or skilled nursing facility;
4. extended care facility;
5. convalescent hospital;
6. facilities for alcoholics, drug addicts or the mentally ill;
7. any other facility which is not a general hospital;
8. any part of a general hospital which:
    a. is designated as a long term care or extended care section; or
    b. is not primarily devoted to the diagnosis and short term treatment of Illness or Injury.

Hospital Sub-Acute Intensive Care Unit means a place which:

1. is a specific area of a Hospital that provides care for patients on a medical level below an intensive care unit, but above a regular room or ward;
2. is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement;
3. is equipped with lifesaving equipment to care for the critically ill or injured; and
4. is under continuous observation by specially trained nursing staff.

The Hospital Sub-Acute Intensive Care Unit may also be referred to as a progressive care unit, intermediate care unit, or a step-down unit but must still meet the criteria noted above.

Illness means sickness, disease, pregnancy, or complications of pregnancy.

Injury means physical damage to an Insured Person’s body which is caused by or a result of a Covered Accident.

Insured Person means the Primary Insured, an Enrolled Employee or an Enrolled Dependent insured under this coverage.

Intensive Care Unit means a place which:

1. is a specific area of a Hospital designated for critically ill or injured patients who require intensive care;
2. is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement;
3. is equipped with lifesaving equipment to care for the critically ill or injured;
4. has a physician assigned to the Intensive Care Unit on a full-time basis; and
5. has 24 hour continuous nursing care by nurses assigned to the unit on a full-time basis.

The term "Intensive Care Unit" as used herein does not include:

1. an intermediate care unit;
2. a private monitored room;
3. a progressive care unit;
4. a Sub-Acute Intensive Care Unit;
5. an observation unit; or
6. any other facility not meeting the definition of an "Intensive Care Unit."

Medically Necessary or Medical Necessity means that the hospitalization is required to diagnose or treat an Insured Person's Illness or Injury and such hospitalization is determined by us to be:

1. consistent with the symptoms or diagnosis and treatment of the Insured Person's Illness or Injury;
2. appropriate with regard to standards of good medical practice;
3. not primarily for the convenience of an Insured Person or the provider of services;
4. the most appropriate level of care which can be safely provided to the Insured Person.

Medically necessary does not include care that is primarily "custodial or maintenance care." This is care that helps a person conduct activities of daily living and that can be provided by people without medical or paramedical skills; for example, help or training in: (a) bathing; (b) eating; (c) dressing; or (d) getting in or out of bed. Custodial care also includes care that is primarily for the purpose of separating a patient from others or preventing a patient from harming himself.

Noncontributory Insurance means you are not required to pay any part of the premium for this coverage.

Non Work-Related Accident means an Accident that occurs while an Insured Person is not working at any job for wage or benefits.

Observation Unit means a place which:

1. is a specific area of a Hospital separate and apart from the emergency room, where patients are monitored following surgery or treatment in the emergency room;
2. provides services under the supervision of a staff physician;
3. is staffed by nurses assigned to the unit; and
4. provides care 24 hours a day, seven days per week.

Occupational Illness or Injury means an Illness or Injury that was caused by or aggravated by any employment for wage or profit.

Occupational Therapist means a person who possesses the designation "Occupational Therapist Registered" (OTR); and provides occupational therapy and services within the scope of his or her state license. The Occupational Therapist cannot be the Insured Person, or related to the Insured Person by blood, marriage, or business affiliation.

Physical Therapist means a person who is licensed by the state to practice physical therapy and provides services within the scope of his or her state license. The Physical Therapist cannot be the Insured Person, or related to the Insured Person by blood, marriage, or business affiliation.

Physician means a person who is providing medically necessary services for diagnosis or treatment of Illness or Injury. Such services must be within the scope of the provider's state license or registry. The Physician cannot be the Insured Person, or related to the Insured Person by blood, marriage, or business affiliation.

Policy, when capitalized, means the insurance policy issued and delivered to the Policyholder, including any endorsements, amendments and/or riders.

Policyholder means the person, individual firm, trust or other organization named in the Application for the Policy and to whom the Policy has been issued.

Primary Insured means:

1. the person who was originally eligible as an Employee to elect coverage under the Group Policy;
2. the Spouse of an Employee if Spouse only coverage is available and elected; or
3. a Spouse who has elected to continue coverage under the Direct Bill Plan for themselves and their Dependent Child(ren) without the continuation of the Employee's coverage.

Proceeds means the amount of insurance we will pay as a benefit. This amount is based on the class of insurance for which the person is eligible on the last day of Active Work according to the Coverage Outline.

Proof or **Proof of Loss** means a properly completed claim form; **plus:**

1. for **Accident –** an itemized bill(s), including date(s) of service, diagnosis code(s), procedure code(s) and charge(s);
2. for **Accidental Death -** in addition to the certified death certificate:
   a. coroner's report;
   b. investigating agency's report or police records;
   c. Employer's Workers' Compensation report of claim, if applicable; and
   d. news accounts, if available;
3. for **Accidental Dismemberment -**
   a. medical records;
   b. investigating agency's report or police records;
   c. Employer's Worker's Compensation report of claim, if applicable; and
   d. news accounts, if available.

Rehabilitation Unit means a place that:

1. provides inpatient rehabilitative care services;
2. provides care that consists of the combined use of medical, social, educational, and vocational services; and
3. provides services under the supervision of Physicians.

The term "Rehabilitation Unit" as used herein does not include:

1. nursing home;
2. hospice care facility;
3. assisted living or skilled nursing facility;
4. extended care facility;
5. convalescent hospital; or
6. a place for alcoholics, drug addicts or the mentally ill.

Spouse means your legal husband, wife, non-state certified domestic partner (if applicable) or state certified domestic partner.

Trauma or Urgent Care Center means a facility that is licensed to service medical emergencies requiring immediate treatment. Trauma Center or Urgent Care Center does not mean a Physician's office.

Work-Related Accident means an Accident that occurs while an Insured Person is working at any job for wages or benefits.

ELIGIBILITY AND ENROLLMENT

This section explains how and when an Employee and his or her Dependents may enroll under the Policy.

A. Eligibility

You become eligible to apply for coverage on the date you have been Actively at Work for the Policyholder long enough to satisfy any required Eligibility Waiting Period.

Your eligibility date is the **later** of:

1. the Effective Date of the Policy; or
2. the date specified in the Coverage Outline which follows your completion of the Eligibility Waiting Period.

If you are a former Employee who is rehired within six months of the date your employment terminated and, you did not enroll under the Direct Bill Plan, your previous service in an eligible class will apply toward the Eligibility Waiting Period to determine your eligibility date. Your coverage however, will be subject to the premium rate for your and your dependents age at the time of re-enrollment.

Dependents

A Dependent becomes eligible for coverage on the **later** of the following dates:

1. the date you become eligible; or
2. the date the person becomes a Dependent.

Dependents are limited to the following:

1. your Spouse; or
2. your or your Spouse's Dependent Child(ren).

B. Enrollment

To enroll for Voluntary Accident Only Insurance for yourself and your eligible Dependents, you must complete and sign an enrollment form and deliver it to the Employer.

Newly Eligible Dependents

You may enroll a Dependent who becomes eligible for coverage after your Effective Date by completing and submitting an enrollment request to us.

Your request for enrollment of a new Dependent Child by birth, adoption, or placement for adoption must be made within 60 days of the date of birth, adoption, or placement for adoption. However, notice is NOT required if you are already paying premium for coverage on your children. Additional premium, if any, will begin on the first premium due date following the child's date of birth or placement.

Request for enrollment of any other newly eligible Dependent must be made within 31 days of the date the Dependent attains eligibility. You must pay any additional premium for the newly Enrolled Dependent(s).

C. Effective Date of Coverage

Subject to the Actively at Work Provision, you and your eligible Dependents will become insured:

1. for Noncontributory Insurance on your eligibility date; or
2. for Contributory Insurance on the **later** of:
    a. the Effective Date of the Policy; or
    b. the coverage Effective Date assigned by us as follows:
        i. if you and/or your Dependents enroll within 31 days after first becoming eligible, coverage will take effect on the first day of the month following the date you apply for coverage; or
        ii. if you and/or your Dependents enroll more than 31 days after first becoming eligible, coverage will take effect on the Effective Date assigned by us.

Coverage for newly eligible Dependents will begin on their Effective Dates (which, for a new Dependent Child by birth, adoption, or placement for adoption, is the date of birth, adoption, or placement for adoption, if enrolled within the specified 60 days).

D. Actively At Work Provision

Coverage will take effect as scheduled only if you are Actively at Work all day on the last regular working day before the scheduled Effective Date. If you are absent from work due to Illness (including pregnancy or complications of pregnancy) or Injury; coverage will not become effective until the first day after you complete one full day of Active Work.

However, coverage will take effect on your regular day off, a holiday, or a paid vacation day, if the regularly scheduled Effective Date falls on that date and you were Actively at Work on the last regular working day before that date.

E. Annual Enrollment Period

The Annual Enrollment Period is the period of time to be determined by the Policyholder and us during which you and/or your Eligible Dependents may enroll for coverage if you and/or your Eligible Dependents did not enroll when initially eligible. You must submit an application on behalf of all dependents you wish to enroll. Coverage for you and your Eligible Dependents will commence on the coverage Effective Date assigned by us upon approval of your application, subject to the Actively at Work Provision.

DESCRIPTION OF BENEFITS

The benefits described in this Policy are payable once per Insured Person, per Covered Accident unless otherwise specifically noted in this section.

ACCIDENTAL DEATH AND DISMEMBERMENT

Accidental Death

If an Insured Person dies as the result of a Covered Accident, we will pay the amount of the Proceeds shown in the Schedule of Benefits to the beneficiary(ies). We must receive satisfactory proof that the accidental death occurred within 365 days of a Covered Accident.

Common Carrier

If an Insured Person dies as a result of a Covered Accident while traveling on a Common Carrier, we will pay the amount of Proceeds shown in the Schedule of Benefits to the beneficiary(ies). We must receive satisfactory proof that the Insured Person died as the result of a Covered Accident while traveling as a fare-paying passenger on a Common Carrier. The accidental death must occur within 365 days of the Covered Accident.

If the Common Carrier benefit is paid, the Accidental Death benefit will not also be paid.

Accidental Dismemberment

If an Insured Person suffers a loss shown below as a result of a Covered Accident, we will pay the amount of Proceeds shown in the Schedule of Benefits for the applicable Accidental Dismemberment loss. The loss must occur within 365 days of the Covered Accident. For the purposes of this benefit, the following definitions apply:

1. Loss of **Hand** or **Foot -** complete severance through or above the wrist or ankle joint;
2. Loss of **Finger** or **Toe -** complete severance through or above the metacarpophalangeal joints;
3. Loss of **Sight -** entire and unrecoverable loss of sight;
4. Loss of **Speech** or **Hearing** - entire and unrecoverable loss of speech or hearing (loss in both ears), that cannot be corrected to a functional level by any procedure or device;
5. Loss of **use of an Arm** – loss of function of the whole arm from the shoulder to the hand;
6. Loss of **Arm –** the arm is cut off above the elbow;
7. Loss of **use of a Leg** – loss of function of the whole leg from the hip to the foot;
8. Loss of **Leg** – the leg is cut off above the knee.

The Accidental Dismemberment benefit is payable once per Insured Person, per Covered Accident. If an Insured Person sustains more than one loss due to a Covered Accident, the loss with the highest benefit will be paid. If an Insured Person loses a finger or toe and then later loses the same hand or foot within 365 days of the first loss due to the same Covered Accident, we will pay the benefit due for the loss of hand or foot, less the amount already paid due to the loss of the finger or toe.

ADMISSION AND CONFINEMENT

Hospital Admission
If an Insured Person is admitted to a Hospital or Hospital Sub-Acute Intensive Care Unit, we will pay the amount shown in the Schedule of Benefits. The Insured Person must be admitted due to Injuries sustained from a Covered Accident. Such admission must occur within 180 days after the Covered Accident. This benefit is not payable for an Emergency Room visit or treatment; outpatient treatment; or a hospital stay of less than 20 hours.

Hospital Confinement
If an Insured Person is confined to a Hospital or Sub-Acute Intensive Care Unit within 180 days after a Covered Accident, we will pay the daily amount shown in the Schedule of Benefits. We will pay this amount up to 365 days per Insured Person, per Covered Accident. The Insured Person must be confined due to Injuries sustained from a Covered Accident and such confinement must be Medically Necessary. This benefit is not payable for an Emergency Room visit or treatment; outpatient treatment; or a hospital stay of less than 20 hours.

Only one confinement benefit is payable at a time. If you are receiving the Hospital Confinement benefit, you may not also receive an Intensive Care Unit or Rehabilitation Unit Confinement benefit for the same confinement dates.

Intensive Care Unit Admission
If an Insured Person is admitted to an Intensive Care Unit due to Injuries sustained from a Covered Accident, we will pay the amount shown in the Schedule of Benefits. This benefit is not payable for an Emergency Room visit or treatment; outpatient treatment; or a hospital stay of less than 20 hours. The Insured Person's initial admission to the Intensive Care Unit must occur within 30 days after the Covered Accident.

Intensive Care Unit Confinement
If an Insured Person is confined to an Intensive Care Unit within 30 days after a Covered Accident, we will pay the daily amount shown in the Schedule of Benefits. We will pay this amount up to 15 days per Insured Person, per Covered Accident. The Insured Person must be confined due to Injuries sustained from a Covered Accident and such confinement must be Medically Necessary.

Only one confinement benefit is payable at a time. If you are receiving the Intensive Care Unit Confinement benefit, you may not also receive a Hospital Confinement or Rehabilitation Unit Confinement benefit for the same confinement dates.

Rehabilitation Unit Confinement
If an Insured Person is confined to a Rehabilitation Unit immediately following a period of Hospital Confinement due to a Covered Accident, we will pay the daily amount shown in the Schedule of Benefits. We will pay this amount up to 15 days per Insured Person, per Covered Accident. Such confinement must be Medically Necessary.

Only one confinement benefit is payable at a time. If you are receiving the Rehabilitation Unit Confinement benefit, you may not also receive a Hospital Confinement or Intensive Care Unit Confinement benefit for the same confinement dates.

SPECIFIC INJURIES AND PROCEDURES

Burn
If an Insured Person is burned, we will pay the amount shown in the Schedule of Benefits, subject to the burn description shown in the Schedule of Benefits. The burn must be the result of a Covered Accident and the Insured Person must seek treatment for the burn within 72 hours of the Covered Accident. If the Insured Person receives burns of multiple degrees, we will pay the highest benefit; however, only one burn benefit is payable per Insured Person, per Covered Accident.

Burn with Skin Graft
If an Insured Person has received a burn benefit under the Policy and also receives a skin graft due to the burn, we will pay the Burn with Skin Graft benefit shown in the Schedule of Benefits.

Coma
If an Insured Person is in a Coma as a result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The Insured Person must be diagnosed with or receive treatment for a Coma lasting for a period of seven or more consecutive days. The Coma must be diagnosed or treated by a Physician within 90 days of the Covered Accident.

Concussion
If an Insured Person sustains a concussion as a result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The concussion must be diagnosed or treated by a Physician within 72 hours of the Covered Accident.

Dislocation
If an Insured Person sustains a dislocation (completely separated joint) as a result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The dislocation must be diagnosed by a Physician within 90 days after the Covered Accident. It must be corrected via an open (surgical) or closed (non-surgical) reduction under anesthesia by a Physician.

If a Physician diagnoses the dislocation as incomplete (the joint is not completely separated), or the dislocation requires treatment without anesthesia by a Physician, we will pay 25 percent of the benefit shown for a closed reduction of a dislocation for that joint.

If an Insured Person sustains one or more fractures and dislocations due to the same Covered Accident, we will pay both benefits. We will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

This benefit is payable once per joint, per Insured Person. Further dislocations of the same joint will not be covered under the Policy after a dislocation benefit has already been paid for that joint.

Emergency Dental Work
If an Insured Person has broken a sound, natural tooth as a result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The broken tooth must be repaired with a crown, denture or implant; or the broken tooth must result in extraction of the tooth. The tooth repair or extraction must occur within 60 days after the date of the Covered Accident. One benefit is payable per Covered Accident, regardless of the number of teeth that are repaired or extracted due to the Covered Accident.

Eye Injury
If an Insured Person sustains an eye Injury due to a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The eye Injury must require surgery or the removal of a foreign body by a Physician within 90 days after the Covered Accident occurs. An examination with anesthesia will not be considered surgery.

Fracture
If an Insured Person sustains a fracture (broken bone) due to a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The fracture must be diagnosed by a Physician within 90 days after the Covered Accident. It must be corrected via an open (surgical) or closed (non-surgical) reduction by a Physician.

If an Insured Person sustains more than one fracture due to the same Covered Accident, we will pay a benefit for all fractures, to a maximum of two times the amount shown in the Schedule of Benefits for the bone involved with the highest benefit amount.

If an Insured Person is diagnosed by a Physician as having a chip fracture (a piece of the bone is broken off near a joint at a place where a ligament is usually attached), we will pay 25 percent of the benefit shown in the Schedule of Benefits for a closed reduction of a dislocation for that joint.

If an Insured Person sustains more than one fracture in a Covered Accident, the maximum benefit is two times the amount for the bone with the highest benefit amount. If an Insured Person sustains a fracture and a dislocation due to the same Covered Accident, we will pay both benefits. We will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

Tear of Knee Cartilage
If an Insured Person has torn, ruptured or severed knee cartilage as a result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The torn knee cartilage must be treated by a Physician within 60 days after the Covered Accident and must be surgically repaired within 365 days after the date of the Covered Accident. If exploratory or arthroscopic surgery is performed without repair, or if the cartilage is shaved, we will pay the Surgery – Exploratory and Arthroscopic benefit.

Laceration (cut)
If an Insured Person receives a laceration due to a Covered Accident, we will pay the corresponding amount shown in the Schedule of Benefits. The laceration must fit one of the descriptions in the Schedule of Benefits in order for a benefit to be payable. The laceration must be repaired by a Physician within 72 hours after the Covered Accident occurs. If the laceration is severe enough to require stitches but your Physician chooses to repair the laceration with an alternate method, the benefit will paid the same as a laceration repaired with stitches.

If an Insured Person receives a laceration due to a Covered Accident and then later loses a digit, hand, foot, eye or limb due to the laceration, we will pay the amount shown in the Schedule of Benefits for the Accidental Dismemberment loss, less the laceration benefit already paid.

Ruptured Disc with Surgical Repair
If an Insured Person ruptures a disc as a result of a Covered Accident and surgical repair is performed, we will pay the amount shown in the Schedule of Benefits. The Insured Person must seek treatment for the ruptured disc within 60 days after the Covered Accident. Surgical repair must be performed within 365 days after the Covered Accident.

Surgery – Cranial, Open Abdominal and Thoracic/Hernia
If an Insured Person undergoes cranial, open abdominal or thoracic surgery (other than hernia repair), we will pay the amount shown in the Schedule of Benefits. Surgery must be performed within 72 hours of the Covered Accident.

If an Insured Person undergoes surgery for a hernia and the hernia is the result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The hernia must be diagnosed within 30 days of the Covered Accident and surgery to repair the hernia must be performed within 60 days of the Covered Accident.

If an Insured Person has cranial, open abdominal, or thoracic surgery and hernia surgery as a result of the same Covered Accident, we will pay the benefit with the highest amount.

Surgery – Exploratory and Arthroscopic
If an Insured Person has exploratory or arthroscopic surgery as a result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The surgery must be to explore or repair Injuries from a Covered Accident; and must occur within 60 days after the Covered Accident. Hernia repair is not covered under this benefit.

Surgery -- Tendon, Ligament and Rotator Cuff
If an Insured Person injures a tendon, ligament or rotator cuff as a result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The Insured Person must be treated by a Physician within 60 days after the Covered Accident. The tendon, ligament or rotator cuff must be ruptured, torn or severed and must be surgically repaired within 365 days after the Covered Accident occurs.

TRANSPORTATION AND LODGING

Ambulance
If an Insured Person is transported in an ambulance due to a Covered Accident within seven days after the Covered Accident, we will pay the amount shown in the Schedule of Benefits. The Insured Person must be transported to or from a Hospital or between medical facilities where treatment for a Covered Accident is received. The transportation must be by a licensed professional ambulance company.

Air Ambulance
If an Insured Person is transported via air ambulance due to a Covered Accident within 48 hours after the Covered Accident, we will pay the amount shown in the Schedule of Benefits. The Insured Person must be transported to or from a Hospital or between medical facilities where treatment for a Covered Accident is received. The transportation must be by a licensed professional air ambulance company.

Lodging
We will pay the lodging benefit shown in the Schedule of Benefits for the friend or family member of an Insured Person during the period the Insured Person is confined due to a Covered Accident to a Hospital more than 75 miles from the Insured Person's residence. The benefit will be payable for one room if the friend or family member incurs a charge for staying in a hotel or motel while the Insured Person is confined. This benefit is payable for up to 15 days, per Covered Accident.

Transportation
We will pay the transportation benefit shown in the Schedule of Benefits if an Insured Person is required to travel more than 50 miles from his or her residence in order to be Hospital confined for treatment of Injuries resulting from a Covered Accident. The treatment must be prescribed by a Physician and not available within 50 miles of the Insured Person's residence. This benefit is payable for up to three trips (round-trip) per Insured Person, per Covered Accident.

This benefit is not payable when the Insured Person is transported by an ambulance or air ambulance.

OTHER SERVICES

Accident Emergency Treatment
If an Insured Person is treated for an Injury in a Hospital Emergency Room, Urgent Care Center or Physician's office due to a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The Insured Person must be treated within 72 hours after the Covered Accident occurs.

Accident Follow-up Visit
If an Insured Person receives treatment for Injuries due to a Covered Accident, we will pay the amount shown in the Schedule of Benefits. Initial treatment must occur more than 72 hours after the Covered Accident, but not later than 60 days after the accident, and does not include occupational or physical therapy. Treatment must be provided by a Physician and must occur in a Physician's office, Urgent Care Center or Emergency Room.

This benefit is not payable for routine examinations or preventive testing and will not be paid more than 365 days after the date of the Covered Accident.

This benefit is payable up to four times per Insured Person, per Covered Accident.

Appliance
If an Insured Person is requires the use of an appliance due to a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The appliance must be prescribed by a Physician and used within 90 days of the Covered Accident. Appliance means a:

1. back brace;
2. cane
3. crutches;
4. leg brace;
5. walker; or
6. wheelchair.

Blood, Plasma and Platelets
If an Insured Person requires the transfusion, administration and processing of blood, plasma or platelets as a result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The blood, plasma or platelets must be administered within 90 days after the Covered Accident occurs.

Imaging Study
If an Insured Person has a medical imaging study due to a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The study must be prescribed by a Physician and performed within 180 days after the Covered Accident. For the purposes of this benefit, a medical imaging study is a:

1. Magnetic Resonance Imaging (MRI) or Magnetic Resonance (MR);
2. Computed Tomography (CT) imaging or Computed Axial Tomography (CAT) Scan; or
3. Electroencephalogram (EEG).

Occupational or Physical Therapy
If an Insured Person requires occupational or physical therapy due to a Covered Accident, we will pay the daily amount shown in the Schedule of Benefits. We will pay this benefit for up to 10 days per Insured Person, per Covered Accident. The therapy must begin within 180 days after the date of the Covered Accident. No benefit will be payable for therapy that occurs more than 365 days from the date of the Covered Accident.

Prosthetic Device
If an Insured Person requires a prosthetic device as a result of a Covered Accident, we will pay the amount shown in the Schedule of Benefits. This benefit is payable for a prosthetic device or artificial limb which is received within 365 days of the Covered Accident and is prescribed by a Physician. The prosthetic device must be received due to a Covered Accident which resulted in the loss of a hand, arm, foot, leg or sight of an eye.

Prosthetic device does not include hearing aids, dental aids (including false teeth), joint replacements, eye glasses or cosmetic prosthesis.

X-Ray
If an Insured Person has an X-ray due to a Covered Accident, we will pay the amount shown in the Schedule of Benefits. The X-ray must be ordered by a Physician and done in a Physician's office or Hospital. The X-ray must be taken within 90 days after the Covered Accident occurs. The X-ray benefit is not payable for the imaging studies listed under the Imaging Study benefit.

EXCLUSIONS AND LIMITATIONS

This Policy does not cover any loss due to:

1. Illness;
2. any Injury sustained prior to the Insured Person's Effective Date of coverage;
3. participation in a felony;
4. intentionally self-inflicted injuries, suicide, or any attempt at suicide, regardless of mental capacity;
5. participation in parachuting, bungee jumping or hang gliding sports, or an organized race or speed contest involving motor vehicles of any type;
6. being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Physician;
7. any bacterial infection except pyogenic infections which occur due to an Accidental Injury;
8. participation in a war, declared or undeclared, or any act of war ('war" includes military activity by one or more national governments; "war" does not include terrorist acts, other random acts of violence not perpetuated by the insured, or civil war or a local or community faction);
9. service in the armed forces of any country;
10. active participation in a riot or insurrection ("participation in a riot or insurrection" includes instigators and those pursuing participation and does not include civil commotion, disorder, injury as an innocent bystander, or injury for self-defense);
11. engaging in any illegal or fraudulent occupation, work, or employment;
12. commission of a crime for which you have been convicted;
13. operating or riding in any kind of aircraft except as a fare-paying passenger on a regularly scheduled commercial flight; or
14. a Work-Related Accident.

CONTINUATION OF COVERAGE

Direct Bill Plan

If you or an Enrolled Dependent lose eligibility under the Policy for any of the following reasons, **you or your Enrolled Dependents may continue coverage under the Direct Bill Plan** if within 31 days of the date your group coverage terminates you:

1. make written request to us at our Home Office; and
2. pay the first Direct Bill premium payment to us.

The Direct Bill application and information regarding Direct Bill Plan premium rates can be obtained from your Employer or you may reach us by phone at (800) 794-5390.

Coverage under the Direct Bill Plan will not be provided for any person if his or her coverage under the Policy terminated due to a failure to make required premium contributions.

The benefits, terms and conditions of the Policy under the Direct Bill Plan will be the same as those provided under the Group Policy when the Insured Person's eligibility under the Group Policy ended. Continued coverage under the Direct Bill Plan will take effect on the day after coverage under the Group Policy terminates. Any change made to the Group Policy after an Insured Person is covered under the Direct Bill Plan will not apply to that Insured Person unless it is required by law.

Premiums are due and payable in advance to us at our Home Office the first day of each premium period.

If You Are No Longer Eligible as explained in the following paragraphs, you and your Enrolled Dependents' coverage ends on the last day of the monthly period in which your eligibility ends. However, it may be possible for you and/or your Enrolled Dependents to continue coverage under the Direct Bill Plan.

Policy Termination or Non Renewal by the Policyholder or by us means coverage ends for you and your Enrolled Dependents on the date the Policy is terminated or not renewed, except that you may continue coverage under the Direct Bill Plan.

In the event this Policy is terminated and coverage is not replaced by the Policyholder, we will mail to the Policyholder a notice of termination. It is then the duty of the Policyholder to send each Enrolled Employee a notice of the termination, explaining rights to continuation of coverage.

Termination Due to Non Payment of Premium by the Employer

If the Policyholder fails to remit the required timely payment of premium, this Policy will terminate and coverage will end for you and all Enrolled Dependents on the last day of the period for which the required contribution has been received. In this event, you may continue coverage under the Direct Bill Plan.

In the event this Policy is terminated due to non-payment of premium by the Policyholder, we will mail to each Primary Insured a notice of termination, explaining rights to continuation of coverage.

Termination of Your Employment or You Are Otherwise No Longer Eligible

If you are no longer eligible due to termination of employment or you are otherwise no longer eligible according to the terms of the Policy, your coverage will end for you and all Enrolled Dependents on the last day of the monthly period following the date on which eligibility ends, except that you may continue coverage under the Direct Bill Plan.

Temporary Layoff or Labor Dispute

Coverage may be continued with premium payment during a temporary layoff or labor dispute, including any strike, work slowdown, or lockout with continued premium payment.

If eligible, coverage will be continued under the Group Policy through the end of the month that immediately follows the month in which the temporary layoff or labor dispute begins. After this time coverage may be continued under the Direct Bill Plan.

Military Service Leave of Absence
Coverage may be continued with premium payment during a leave of absence for military service of 30 days or more with continued premium payment.

If eligible, coverage will be continued under the Group Policy for up to the greater leave period provided under Leave of Absence or Family and Medical Leave of Absence. After this time coverage may be continued under the Direct Bill Plan.

Family and Medical Leave
Coverage may be continued with premium payment during a Family and Medical Leave of Absence as defined by the Federal Family and Medical Leave Act of 1993, and any amendments.

If eligible, coverage will continue for up to the greater of the leave period required under the:

1. Federal Family and Medical Leave Act of 1993, and any amendments; or
2. applicable state law.

This leave provision is available only to employers that are required by law to comply. The Employer must keep us advised regarding the eligibility for coverage of any Employee who may be entitled to extension of benefits under FMLA.

Leave of Absence:
Coverage may be continued with premium payment during a leave of absence approved in writing in advance by your Employer.

If eligible, coverage will continue through the end of the month that immediately follows the month in which the leave of absence begins. After this time coverage may be continued under the Direct Bill Plan.

If Your Enrolled Dependents Are No Longer Eligible as explained in the following paragraphs, his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for your Enrolled Dependents to continue coverage under the Direct Bill Plan.

Divorce, or Annulment or Termination of Domestic Partnership
Eligibility ends for your enrolled Spouse and the Spouse's children (unless such children remain eligible by virtue of their continuing relationship to you) on the last day of the monthly period following the date a divorce, annulment or termination of domestic partnership is final. However, your Spouse may elect to continue coverage under the Direct Bill Plan for themselves, as the Primary Insured, and their Dependent Child(ren) without the continuation of your coverage.

If You Die
If your coverage terminates due to your death, your surviving Spouse will have the opportunity to become the Primary Insured under the Direct Bill Plan, if the Spouse is an Insured Person. If there is no surviving Spouse covered under this plan, then this plan will terminate on the next premium due date.

When Coverage under the Direct Bill Plan Ends
Coverage under this provision ends for all Insured Persons on the earliest of the following dates:

1. The date the Employee again becomes eligible for coverage under this Group Policy;
2. the last day for which premiums have been paid, if the premiums are not paid when due, subject to the grace period provision; or
3. upon your written request.

WHEN COVERAGE ENDS

This section describes the situations when coverage will end for you and/or your Enrolled Dependents. If one of your Enrolled Dependents is no longer eligible for this coverage, you must notify us within 30 days.

Loss of Eligibility
Unless the coverage is continued under the Direct Bill Plan, your coverage ends on the earliest of the following dates:

1. the last day of the monthly period in which you cease to be an Employee or otherwise fail to meet the eligibility requirements of the Policy;
2. the date your employment with a Participating Employer terminates;
3. the date the Policy terminates; or
4. the date your Employer ceases participation with the Policyholder.

Nonpayment of Premium
If you fail to make the required premium contributions, your coverage will end for you and all Enrolled Dependents on the last day of the period for which you have made the required contribution.

Termination by You
You have the right to terminate this coverage with respect to yourself and your Enrolled Dependents by giving written notice to your Employer or directly to us.

Coverage will end on the last day of the premium period following:

1. the date you specify, if the date specified is later than the date notice is received; or
2. the earlier of:
   a. the date written notice is received by your Employer; or
   b. the date written notice is received by us.

Note: If you voluntarily terminate your coverage, you will not have the opportunity to re-enroll during the next two Annual Enrollment Periods following your termination date.

If You Die
If your coverage terminates due to your death and there is no surviving Spouse covered under this plan, then this plan will terminate on the next premium due date.

Loss of Dependent Status
Coverage for a Dependent ends on the earliest of the following dates:

1. for the Spouse, the last day of the monthly period following the date a divorce, annulment or termination of domestic partnership is final, unless coverage is continued under the Direct Bill Plan;
2. for a Dependent Child, the last day of the monthly period in which the child ceases to be a Dependent Child as defined in the Definitions section of this Policy;
3. the last day of the period for which you make the required premium contribution; or
4. upon your written request.

Termination without Prejudice
If termination of coverage occurs, such termination shall be without prejudice to any loss which incurred while this coverage was in force.

Fraudulent Use of Benefits
If you or your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of fact in connection with coverage, coverage under this Policy will terminate for that Insured Person. If this coverage terminates due to fraud by the Primary Insured, it will also terminate for all Enrolled Dependents.

CLAIM INFORMATION

This section explains some of the terms and conditions relating to payment of claims.

Claim Forms
We will furnish the claim forms for filing Proof of Loss within 15 days after they are requested. If we do not do so, you may comply with the Proof of Loss requirements of the Policy by submitting written Proof showing the occurrence, nature and extent of the loss for which claim is made.

Proof of Loss
Written Proof of Loss must be received within 90 days after the date of the loss for which a claim is made.

Failure to furnish Proof of Loss will not invalidate nor reduce any claim if it is not reasonably possible to give Proof of Loss within 90 days, provided the Proof of Loss is furnished as soon as reasonably possible. However, in no event, except in the absence of legal capacity of the claimant, may Proof of Loss be given later than one year from the time Proof of Loss is otherwise required.

All Proof of Loss submitted must be satisfactory to us.

Physical Exam and Autopsy
We have the right and opportunity to have a person whose injury or illness is the basis of a claim examined by a Physician of our choice at our expense. This right may be used as often as reasonably required while the claim is pending and, in the case of death, includes an autopsy, where it is not forbidden by law.

Payment of Claims
We will pay the Proceeds for insured losses as soon as we receive satisfactory Proof of Loss. Benefits for Accidental Death will be paid to your Beneficiary(ies). Benefits for ambulance transportation will be paid directly to the provider of the ambulance transportation. All other benefits due under the Policy will be paid to you.

Facility of Payment
If you die while insured under the Policy, we will pay the applicable Proceeds to your Beneficiary(ies) when we receive Proof of your death due to a Covered Accident.

Proceeds are based on the class of insurance for which you are eligible on the last day of Active Work according to the Coverage Outline. The following paragraphs describe to whom we will pay the Proceeds when you die. Our liability for the payment ends if we make it in good faith.

Payment to Beneficiaries
We will pay the Proceeds to the designated Beneficiary or Beneficiaries listed on your enrollment form. If one or more Beneficiaries die before you, the deceased Beneficiaries and their estates have no rights to the Proceeds. Two or more surviving Beneficiaries will share equally, unless otherwise specified.

When there is no Surviving Beneficiary
If there is no designated Beneficiary, or if the designated Beneficiary does not survive you, we will pay the Proceeds in equal shares to your surviving relatives of the highest rank of the following:

1. spouse;
2. children;
3. parents; or
4. your estate.

Children, for the purposes of the Facility of Payment provision only, means biological and adopted children.

If the Beneficiary is a Minor or Incompetent
If a Beneficiary is a minor or not competent, we have the right to pay up to $1,000 to the person or institution who appears to us to have assumed the Beneficiary's custody and principal support. We will take this action until or unless a formal complaint is made by a legal representative of the Beneficiary.

Our liability for the above payment ends if we make it in good faith. We will pay remaining benefits upon Proof acceptable to us of guardianship or conservatorship to the legal estate of the minor child or incompetent Beneficiary.

Additional Payment of Proceeds
We may pay up to $500 of the Proceeds, according to law, to any person who appears to us to have incurred costs from your last Illness, death, or funeral.

Notification of Denied Claims
If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written decision will:

1. give the specific reason(s) for the denial;
2. make specific reference to the policy provisions on which the denial is based;
3. give notice of any additional information that might allow us to change our decision and why the information is necessary;
4. explain your right to ask for a review of your claim; and
5. include instructions for filing an Appeal if you disagree with the action.

Review Procedure
An Insured Person has the right to a review of any denial by us of all or any part of a claim. To obtain a review, a written request for review should be sent to us at our Home Office within 180 days after the Insured Person receives notice of denial. No special form is required. The Insured Person may submit written comments and provide additional documentation in support of the claim, and may review any non-privileged information relating to the request for review.

We will review the claim promptly after receiving the request. We will send the Insured Person written notice of our decision within 45 days after the request for review is received, or within 90 days if special circumstances require an extension. The notice will include the reasons for the decision and will refer to the specific provisions of the Policy on which the decision is based.

Another person may be authorized to act for the claimant under this review procedure.

Additional Information about the claim review process can be obtained by contacting our customer service department at (800) 286-1129, or you can write to our customer service department at the following address: LifeMap Assurance Company, Attention: Accident Only Insurance Customer Service, PO Box 1271, MS E3A, Portland, OR 97207-1271.

You also have the right to file a complaint and seek assistance from the State of Oregon Department of Consumer and Business Services Insurance Division. You can contact them by writing to PO Box 14480, Salem, OR 97309-0405, calling (880) 877-4894 or visiting the Oregon Insurance Division's website at http://insurance.oregon.gov.

Claims Recovery
We have the right to recover any overpayments due to fraud or any error made in processing a claim.

If benefits have been overpaid on any claim, it will be required that reimbursement be made to LifeMap Assurance Company. We have the right to reduce future benefits until such reimbursement is received. In the event of your death, we also have the right to recover such overpayments from your estate.

GENERAL PROVISIONS

Entire Contract-Policy Changes
This Certificate is furnished in accordance with and subject to the terms of the Policy. The entire contract consists of the Policy, which includes the Application, and any attached papers; this Certificate; and any riders or endorsements. No change in the Policy will be effective until approved by one of our officers. This approval can only be made in writing and must be noted on or attached to the Policy. No agent has authority to change the Policy or Certificate or to waive any of their provisions.

Agency
For all purposes under this Policy the Policyholder acts on its own behalf or as agent of the Employee. Under no circumstances will the Policyholder be deemed our agent without a written authorization.

Certificates
The Employer is responsible for giving to the Employee a complete copy of the Certificate for the Employee's applicable class within 31 days after receipt of the Certificates from us.

Premium
We may change the premium rates for this coverage only if we change it for all similar coverage issued to the Policyholder. Any change in premium will be explained to the Policyholder in writing 30 days or more before the change is effective. If you are no longer employed by the Policyholder and pay premium direct to us, we will notify you at the address shown in our records.

Unpaid Premium
We may deduct any unpaid premium then due from the payment of a claim under this coverage.

Refund of Premium
On the death of an Insured Person, we will refund any unearned premium paid for that person beyond the end of the month in which death occurred. Payment will be made no later than 30 days after proof of the Insured Person’s death has been furnished to us.

Grace Period
If you are paying your premium directly to us under the Direct Bill Plan, a grace period will apply to payment of premiums (except the initial premium.) This grace period means that if you pay your premiums within 31 days after they are due, your coverage remains continuously in force. If you do not, your coverage is terminated as of the date the premiums were due.

Assignment
The Policy may not be assigned, but you may assign your rights under the Policy.

Misstatement of Age
If a person's age has been misstated, an equitable adjustment will be made in the premium. If the amount of the benefit is dependent upon the person's age, the benefit amount will be the amount the person would have been entitled to if his or her correct age were known.

NOTE: A refund will not be made for a period more than 12 months before the date we are advised of the error.

Clerical Error or Omission
Clerical error or omission will not:

1. cause an ineligible person to become insured;
2. invalidate insurance otherwise validly in force; or
3. continue insurance validly terminated.

Incontestability
In the absence of fraud, all statements you make in a signed application for coverage, or on an Evidence of Insurability Form, will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by you, a copy of which is furnished to you.

After coverage has been in effect for two years during the lifetime of the Insured Person, no misrepresentation will be used to reduce or deny a claim or to deny the validity of coverage. The validity of the Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.

This two year period will be restarted for applications made:

1. for any requested increase in coverage; and
2. for any benefits added to the Policy that are requested by you and approved by us,

but only for the amount of the increase or added benefit(s).

Insurance Fraud
Insurance Fraud occurs if you and/or your Employer, with intent to knowingly injure, defraud or deceive us, provides us with materially false information or files a claim for benefits that contains materially false, incomplete or misleading information.

We have issued this coverage in reliance upon all information furnished to us by you or on behalf of you and your Enrolled Dependents. In the event of any intentional material misrepresentation of fact or fraud regarding an Insured Person (including, but not limited to a person who is listed as a Dependent, but does not meet the eligibility requirements listed in this Certificate), coverage under this Policy will terminate for such Insured Person.

We may terminate your coverage if you have filed a fraudulent claim or statement with us. We may terminate the Group Policy if the Policyholder or his administrator has filed or assisted with the filing of a fraudulent claim with us.

Any person who knowingly and with intent to defraud any insurance company; or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be subject to prosecution for insurance fraud.

We may use all means available to us to detect, investigate, deter and prosecute those who commit insurance fraud. We may pursue all available legal remedies if you and/or your Employer perpetrate insurance fraud.

Legal Action
No legal action may be brought to recover on this Policy until 60 days after Proof of Loss has been furnished. No action may be brought after 3 years from the time written Proof of Loss is required to be furnished.

Worker's Compensation
This insurance is not in lieu of Workers' Compensation; it does not affect any requirement for Workers' Compensation coverage.

Notices to Insured Persons or to the Employer required in the Policy will be deemed to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Insured Person or to the Employer will be addressed to the Insured Person or to the Employer at the last known address appearing in our records. If we receive a United States Postal Service change of address form (COA) for an Insured Person, we will update our records accordingly. Additionally, we may forward notice for an Insured Person to the plan administrator if we become aware that we don't have a valid mailing address for the Insured Person.

Any notice to us required in the Policy may be given by mail addressed to: LifeMap Assurance Company, PO Box 1271, MS E3A, Portland, OR 97207-1271; provided, however, that any notice to us will not be deemed to have been given to and received by us until physically received by us.