

# The Lincoln National Life Insurance Company

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

Group Policyholder: South Carolina Medical Association

In Consideration of the Group Policyholder's application for this Policy and payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the persons entitled to them.

The first premium for this Policy is due on its effective date. Subsequent premiums are due on January 1, 2011, and on the same day of each month after that. Policy anniversaries will be each December 1; unless shown otherwise on the Premium Rate Schedule inside.

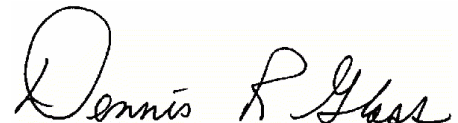
The provisions and conditions set forth on the following pages are a part of this Policy, as fully as if recited over the signatures below.

This Policy is delivered in the State of South Carolina.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. The issue date of this Policy is December 1, 2010.



Secretary



President

**THIS IS A LEGAL CONTRACT BETWEEN  
THE POLICYHOLDER AND THE COMPANY**

**READ YOUR POLICY CAREFULLY**

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

GROUP ACCIDENT INSURANCE POLICY  
No. GL 00040400207400000

**TABLE OF CONTENTS**

SCHEDULE OF BENEFITS ..... 3

DEFINITIONS ..... 11

GENERAL PROVISIONS ..... 16

PROVISIONS APPLICABLE TO PARTICIPATING ORGANIZATIONS..... 18

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL ACCIDENT INSURANCE..... 19

TERMINATION OF PERSONAL ACCIDENT INSURANCE..... 21

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT ACCIDENT INSURANCE ..... 23

TERMINATION OF DEPENDENT ACCIDENT INSURANCE ..... 25

PREMIUMS AND PREMIUM RATES ..... 26

PREMIUM RATE SCHEDULE ..... 26

POLICY TERMINATION ..... 27

EMERGENCY CARE BENEFITS ..... 28

TREATMENT CARE BENEFITS..... 29

SPECIFIC INJURIES OR TREATMENTS ..... 31

TRANSITIONAL CARE BENEFITS..... 33

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS ..... 34

LIMITATIONS AND EXCLUSIONS ..... 35

BENEFICIARY ..... 36

CLAIM PROCEDURES FOR ACCIDENT INSURANCE ..... 37

## **SCHEDULE OF BENEFITS**

### **CLASSIFICATION**

Class 1      All Full-Time Employees

Class 2      Retirees

**ELIGIBILITY WAITING PERIOD (For Date Insurance Begins, Refer To "Effective Date" Section)**

For Classes 1 & 2: None.

**ANNUAL/OPEN ENROLLMENT PERIOD:** November 1 – November 30

**SCHEDULE OF BENEFITS  
(Continued)**

**BENEFITS FOR SELECT PLAN - CLASS 1**

ELIGIBLE CLASS means: All Full-Time Employees

MINIMUM HOURS PER WEEK: 30

CONTRIBUTIONS: Insured Persons are required to contribute to the cost for Personal Accident Insurance. Insured Persons are required to contribute to the cost for Dependent Accident Insurance.

**BENEFITS FOR SELECT PLAN - CLASS 2**

ELIGIBLE CLASS means: Retirees

CONTRIBUTIONS: Insured Persons are required to contribute to the cost for Personal Accident Insurance. Insured Persons are required to contribute to the cost for Dependent Accident Insurance.

**SCHEDULE OF BENEFITS  
(Continued)**

**EMERGENCY CARE BENEFITS**

<b><u>Type of Benefit</u></b>	<b><u>Benefit Amount</u></b>
<b>Ambulance Transportation</b>	\$150
<b>Air Ambulance Transportation</b>	\$600
<b>Emergency Care Treatment</b>	\$150
<b>Initial Physician Office Visit</b>	\$50
<b>Major Diagnostic Exam</b>	N/A

**TREATMENT CARE BENEFITS**

<b><u>Type of Benefit</u></b>	<b><u>Benefit Amount</u></b>
<b>Hospital Admission</b>	\$1,000
<b>Hospital Confinement</b>	\$200
<b>Intensive Care Unit (ICU) Confinement</b>	\$400
<b>Alternate Care and Rehabilitative Facility Confinement</b>	\$100
<b>Follow-up Care</b>	\$50
<b>Transportation</b>	N/A
<b>Lodging</b>	N/A
<b>Family Care</b>	\$20

**SCHEDULE OF BENEFITS  
(Continued)**

**SPECIFIC INJURIES OR TREATMENTS**

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>	
<b>Fractures</b>	<u>Non- Surgical</u>	<u>Surgical</u>
Ankle	\$150	\$300
Arm (shoulder to elbow)	\$150	\$300
Arm (elbow to wrist)	\$150	\$300
Bones of Face (except those listed below)	\$100	\$200
Coccyx	\$100	\$200
Collarbone	\$150	\$300
Elbow	\$150	\$300
Finger	\$25	\$50
Foot (except toes)	\$150	\$300
Hand (except fingers)	\$150	\$300
Hip	\$150	\$300
Kneecap	\$150	\$300
Leg (hip to knee)	\$150	\$300
Leg (knee to ankle)	\$150	\$300
Lower Jaw	\$150	\$300
Nose	\$100	\$200
Pelvis	\$150	\$300
Rib	\$100	\$200
Shoulder blade	\$150	\$300
Skull (depressed)	\$150	\$300
Skull (non-depressed)	\$150	\$300
Sternum	\$150	\$300
Toe	\$25	\$50
Upper Jaw	\$150	\$300
Vertebrae	\$100	\$200
Vertebral Column	\$150	\$300
Wrist	\$150	\$300
Chip Fracture	25% of the amount payable for full fracture	

**SCHEDULE OF BENEFITS  
(Continued)**

**SPECIFIC INJURIES OR TREATMENTS (Continued)**

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>	
<b>Dislocations</b>	<u>Non- Surgical</u>	<u>Surgical</u>
Ankle	\$150	\$300
Collarbone (sternoclavicular)	\$150	\$300
Collarbone (acromio and separation)	\$150	\$300
Elbow	\$150	\$300
Finger	\$25	\$50
Foot (except toes)	\$150	\$300
Hand (except fingers)	\$150	\$300
Hip	\$150	\$300
Knee (not kneecap)	\$150	\$300
Lower Jaw	\$150	\$300
Shoulder	\$150	\$300
Toe	\$25	\$50
Wrist	\$150	\$300
Partial Dislocation	25% of benefit payable for Dislocation	
<b>Transfusions: Blood, Plasma, Platelets</b>	N/A	
<b>Burns</b>		
<u>2<sup>nd</sup> Degree</u>		
< 9%	\$100	
10-18%	\$200	
19-36%	\$400	
37% +	\$800	
<u>3<sup>rd</sup> Degree</u>		
< 9%	\$800	
10-18%	\$1,600	
19-36%	\$3,200	
37% +	\$6,400	
<b>Skin Grafts (due to burns)</b>	25% of benefit payable for Burns	

**SCHEDULE OF BENEFITS  
(Continued)**

**SPECIFIC INJURIES OR TREATMENTS (Continued)**

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>
<b>Coma</b>	\$2,000
<b>Concussion</b>	\$100
<b>Dental Injury - Emergency Dental Work for the following:</b>	
Crown	N/A
Extraction	N/A
<b>Eye Injury</b>	
Removal of foreign body	N/A
Surgical repair	N/A
<b>Joint Replacement</b>	
Hip	N/A
Knee	N/A
Shoulder	N/A
<b>Lacerations</b>	
No Sutures Required	\$50
Sutures Required (Total Length of all sutured Lacerations)	
up to 5cm:	\$100
5.1-15.5cm:	\$200
15.6cm+:	\$400
<b>Knee Cartilage</b>	\$300
<b>Ligaments/Tendons/Rotator Cuff</b>	\$300
<b>Ruptured Disc</b>	\$400
<b>Surgery – Abdominal or Thoracic</b>	\$1,000
<b>Surgery – Arthroscopic</b>	\$250

**SCHEDULE OF BENEFITS  
(Continued)**

**TRANSITIONAL CARE BENEFITS**

<u>Type of Benefit</u>	<u>Benefit Amount</u>
<b>Medical Appliance Assistance</b>	
Crutches	\$25
Wheelchair – expected use less than 1 year	\$50
Wheelchair – expected use 1 year or longer	\$350
Walker – expected use less than 1 year	\$25
Walker – expected use 1 year or longer	\$50
Other Medical Appliance used for mobility	\$25
<b>Prosthesis</b>	\$500
<b>Reasonable Modifications</b>	\$2,500

**SCHEDULE OF BENEFITS  
(Continued)**

**ACCIDENTAL DEATH and DISMEMBERMENT BENEFITS (AD&D)**

<u>Type of Benefit</u>	<u>Benefit Amount</u>
<b>Loss</b>	
Loss of Life	
Insured Person	\$10,000
Insured Dependent Spouse	\$5,000
Insured Dependent Child	\$5,000
Loss of Hand, Foot, Arm, Leg, Eye, or Hearing in One Ear	\$7,000
Any Loss of finger, thumb, or toe	\$300
<b>Common Carrier Accident</b>	2 times AD&D benefit amount
<b>Common Disaster</b>	2 times AD&D benefit amount
<b>Transportation of Remains</b>	\$5,000
<b>Seat Belt/Helmet</b>	10% AD&D benefit amount
<b>Catastrophic Loss</b>	\$50,000
Loss of Sight in Both Eyes	
Loss of Hearing in Both Ears	
Loss of Speech	
Loss of Both Arms and Both Legs	
Loss of Both Arms	
Loss of Both Legs	
Loss of Arm and Leg	

## DEFINITIONS

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

**ACTIVE WORK** or **ACTIVELY AT WORK** means an Employee's performance of all customary duties of his or her occupation at:

- (1) the Group Policyholder's or Participating Organization's place of business; or
- (2) any other business location designated by the Group Policyholder or Participating Organization.

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

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.

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

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

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

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

**CHANGE IN FAMILY STATUS** means a marriage, divorce, birth, adoption, death or change of employment or eligibility status or other event which qualifies under the requirements of Section 125 of the Internal Revenue Code of 1986, as amended. Change in Family Status also means the involuntary loss of comparable coverage under a spouse's benefit plan.

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

**CHILD CARE CENTER** means any facility which:

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

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

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

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

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

## **DEFINITIONS (Continued)**

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

**COVERED ACCIDENT** means an Accident that:

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

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

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

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

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

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

**EMPLOYEE** means a Full-Time Employee of the Group Policyholder or Participating Organization.

**FAMILY OR MEDICAL LEAVE** means an approved leave of absence that:

- (1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
- (2) is taken in accord with the Group Policyholder's or Participating Organization's leave policy and the law which applies; and
- (3) does not exceed the period approved by the Group Policyholder or Participating Organization and required by that law.

The leave period may:

- (1) consist of consecutive or intermittent work days; or
- (2) be granted on a part-time equivalency basis.

If a Person is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If a Person is on an FMLA leave due to his or her own health condition on the date insurance under this Policy takes effect, he or she is not considered Actively at Work.

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

## **DEFINITIONS (Continued)**

**FULL-TIME EMPLOYEE** means a person:

- (1) whose employment with the Group Policyholder or Participating Organization is the person's main occupation;
- (2) whose employment is for regular wage or salary;
- (3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits per week;
- (4) who is a member of an eligible class under this Policy;
- (5) who is not a temporary or seasonal employee; and
- (6) who is a citizen of the United States or legally works in the United States.

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

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

**HOSPITAL** means a general hospital which:

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

It does not include a place that:

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

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

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

**INSURANCE MONTH** means that period of time:

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

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

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

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

## **DEFINITIONS (Continued)**

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

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

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

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

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

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

**MILITARY LEAVE** means a leave of absence that:

- (1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
- (2) is taken in accord with the Group Policyholder's or Participating Organization's leave policy and the federal USERRA law; and
- (3) does not exceed the period required by that law.

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

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

## **DEFINITIONS (Continued)**

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

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

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

**PAYROLL PERIOD** means that period of time established by the Group Policyholder for payment of employee wages.

**PERSON** means a Full-Time Employee or Retiree of the Group Policyholder or Participating Organization:

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

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

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

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

**PHYSICIAN** means:

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

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

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

Relatives include:

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

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

**PREMIUM** means the amount charged for insurance coverage.

**RETIREE** means a former full-time employee of the Group Policyholder or Participating Organization who is eligible for retirement benefits.

**SICKNESS** means:

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

## GENERAL PROVISIONS

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

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

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

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

**AUTHORITY TO MAKE OR AMEND CONTRACT.** Only a Company Officer located in the Company's Group Insurance Service Office has the authority to:

- (1) determine the insurability of a group or any individual within a group;
- (2) make a contract in the Company's name;
- (3) amend or waive any provision of this Policy; or
- (4) extend the time for payment of any premium.

No change in this Policy will be valid, unless it is made in writing and signed by such a Company Officer.

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

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

**NONPARTICIPATION.** This is a non-participating policy. It will not share in the divisible surplus of any Company.

**INFORMATION TO BE FURNISHED.** The Group Policyholder and any Participating Organization may be required to furnish any information needed to administer this Policy, including:

- (1) information about persons:
  - (a) who become eligible for insurance;
  - (b) whose amounts of insurance change; or
  - (c) whose eligibility or insurance ends;
- (2) occupational information and other facts that may be needed to manage a claim; and
- (3) any other information that the Company may reasonably require.

The Company may inspect the Group Policyholder's or any Participating Organization's records that relate to this Policy, at any reasonable time.

Clerical error by the Group Policyholder or any Participating Organization:

- (1) will not void or terminate insurance that otherwise would be in effect;
- (2) will not result in insurance coverage that otherwise would not be in effect; and
- (3) will not continue insurance that otherwise would be terminated.

Once an error is discovered, a fair adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period that precedes the date the Company receives proof such an adjustment should be made.

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

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

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

**GENERAL PROVISIONS**  
**(Continued)**

**ACTS OF THE POLICYHOLDER.** In administering this Policy, the Group Policyholder must:

- (1) treat Employees the same in like situations; and
- (2) allow the Company, without inquiry, to rely on its acts.

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

**CERTIFICATES.** The Group Policyholder will be furnished with individual certificates of insurance for delivery to each Insured Person. These certificates summarize the benefits to which the Insured Person is entitled and to whom the benefits are payable. If there is a conflict between this Policy and the certificate, this Policy will control.

**CONFORMITY WITH STATE STATUTES.** If, on its effective date, any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

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

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

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

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

## PROVISIONS APPLICABLE TO PARTICIPATING ORGANIZATIONS

A Participating Organization has no rights under this Policy except as provided in this section. The Participating Organization will be responsible for all premiums payable with respect to any of its Employees who are Insured Persons under this Policy.

**PARTICIPATING ORGANIZATION** means an organization that has been approved by the Company for participation in the insurance provided by this Policy. The following are Participating Organizations:

Employer Members of the South Carolina Medical Association

**EFFECTIVE DATE.** As it applies to any Participating Organization, the Effective Date of this Policy will be the later of:

- (1) the date this Policy is issued;
- (2) the first day of the Insurance Month following the Company's approval of the organization's Participation Agreement; or
- (3) a date agreed upon by the Company, the Participating Organization, and the Group Policyholder.

**TERMINATION.** A Participating Organization's participation under this Policy ends on the earliest of the following dates:

- (1) the date the organization no longer meets the definition of a Participating Organization;
- (2) the date the Participating Organization suspends active business operations, is placed in bankruptcy or receivership, dissolves, merges or relocates;
- (3) the date the Participating Organization, without good cause, fails to:
  - (a) promptly furnish the Company any information it may reasonably require; or
  - (b) perform its duties pertaining to this Policy in good faith;
- (4) the last day of the Insurance Month for which premium is paid;
- (5) the last day of the Insurance Month in which the Company receives the Participating Organization's written request to cease participation; or
- (6) the date this Policy terminates.

On the day participation ends, Policy insurance will terminate for all Insured Persons of the Participating Organization and their Insured Dependents, unless eligible under the Portability section of this Policy.

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

**ELIGIBILITY.** A Person becomes eligible for insurance provided by this Policy on the latest of:

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

**Prior Service Credit Towards Waiting Period.** The Waiting Period is shown in the Schedule of Benefits. Prior service in an Eligible Class will apply toward the Waiting Period, when:

- (1) a former employee is rehired within 6 months after his or her employment ends; or
- (2) an employee returns from an approved Family or Medical Leave within:
  - (a) the leave period required by federal law; or
  - (b) any longer period required by a similar state law; or
- (3) an employee returns from a Military Leave within the period required by federal USERRA law.

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

- (1) when first eligible;
- (2) during any Annual/Open Enrollment Period; or
- (3) within 31 days following a qualifying Change In Family Status.

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

- (1) the date the Person becomes eligible for the insurance;
- (2) (a) for Class 1: the date the Person resumes Active Work, if not Actively at Work on the day he or she becomes eligible. The Person will be deemed Actively at Work on any regular non-working day, if he or she:
  - (i) is not totally disabled or Hospital confined on that day; and
  - (ii) was Actively at Work on the regular working day before that day; or
- (b) for Class 2: the day after the Person's final discharge from a hospital or other health care facility, if the Person is confined to such a facility on the day he or she would otherwise become eligible; or
- (3) if the Person contributes to the cost of the Personal Accident Insurance, the date the Person makes written application for insurance and pays the required premium to the Company.

For Class 1: Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the date on which the Insured Person becomes eligible for the increase, if Actively at Work on that day; or
- (2) the day the Insured Person resumes Active Work, if not Actively at Work on the date the increase would otherwise take effect.

For Class 2: Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the date on which the Insured Person becomes eligible for the increase; or
- (2) the day after the Insured Person's final discharge from a hospital or other health care facility, if he or she is confined to such a facility on the date the increase would otherwise take effect.

For Classes 1 & 2: Any reduction in insurance or benefits will take effect on the day of the change, whether or not the Insured Person is Actively at Work.

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

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

**REINSTATEMENT RIGHTS.** If an Insured Person's insurance terminates due to one of the following breaks in service, he or she will be entitled to reinstate the insurance upon resuming Active Work with the Group Policyholder or Participating Organization within the required timeframe. "**Reinstatement**" or "**to reinstate**" means to re-enroll for the Policy's insurance coverage, without satisfying a new Eligibility Waiting Period. Reinstatement is available upon:

- (1) return from an approved Family or Medical Leave within:
  - (a) the period required by federal law; or
  - (b) any longer period required by a similar state law;
- (2) return from a Military Leave within the period required by federal USERRA law; or
- (3) return from any other approved leave of absence within 6 months after the leave begins.

To reinstate insurance coverage, the Person must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an eligible class unless the Group Policyholder contributes to the entire cost of the premium. The required premium payments must be received from the Group Policyholder for coverage to be reinstated. Reinstatement will take effect on the date the Person returns to Active Work.

## TERMINATION OF PERSONAL ACCIDENT INSURANCE

**TERMINATION.** An Insured Person's insurance will terminate at 12:00 midnight on the earliest of:

- (1) the date this Policy terminates or the Participating Organization's participation terminates (but without prejudice to any claim incurred prior to termination);
- (2) the date the Insured Person's Class is no longer eligible for insurance;
- (3) the date the Insured Person ceases to be a member of the Eligible Class;
- (4) the last day of the Insurance Month in which the Insured Person requests termination;
- (5) the last day of the last Insurance Month for which premium payment is made on the Insured Person's behalf;
- (6) the end of the period for which the last required premium has been paid;
- (7) with respect to any particular insurance benefit, the date the portion of this Policy providing that type of benefit terminates;
- (8) the date the Insured Person's employment with the Group Policyholder or Participating Organization terminates (unless eligible for retirement benefits); or
- (9) the date the Insured Person enters armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard (If the Person sends proof of military service, the Company will refund any unearned premium.); unless insurance is continued as provided below.

**CONTINUATION RIGHTS.** Ceasing Active Work results in termination of the Insured Person's eligibility for insurance, but insurance may be continued as follows.

**Disability.** If the Insured Person is disabled due to illness or Injury, then insurance may be continued until the earlier of:

- (1) 12 Insurance Months after the disability begins; or
- (2) the date the Person is no longer disabled.

The required premium payments must be received from the Group Policyholder, throughout the period of continued insurance.

**Family or Medical Leave.** If an Insured Person goes on an approved Family or Medical Leave and is **not** entitled to any more favorable continuation available during disability, insurance may be continued until the earliest of:

- (1) the end of the leave period approved by the Group Policyholder or Participating Organization;
- (2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
- (3) the date the Insured Person notifies the Group Policyholder or Participating Organization that he or she will not return; or
- (4) the date the Insured Person begins employment with another employer.

The required premium payments must be received from the Group Policyholder throughout the period of continued insurance.

**Military Leave.** If an Insured Person goes on a Military Leave, insurance may be continued for the same period allowed for an approved Family or Medical Leave or any more favorable leave in which employees with similar seniority, status, and pay who are on furlough or leave of absence are granted by the Group Policyholder or Participating Organization. The required premium payments must be received from the Group Policyholder throughout the period of continued insurance.

**Lay Off or Other Leave.** When an Insured Person ceases work due to a temporary layoff, or due to an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); insurance may be continued for three Insurance Months after the layoff or leave begins. The required premiums must be received from the Group Policyholder throughout the period of continued insurance.

**Conditions.** In administering the above continuations, the Group Policyholder must not act so as to discriminate unfairly among Insured Persons in similar situations. Insurance may not be continued when an Insured Person ceases Active Work due to a labor dispute, strike, work slowdown or lockout.

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

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

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

Portability is not available when insurance terminates solely because an Insured Person's spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earliest of:

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

**INDIVIDUAL TERMINATION.** Termination will have no effect on benefits payable for a Covered Accident that occurred while the Insured Person was insured under this Policy.

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

**DEPENDENT** means an Insured Person's:

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

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

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

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

"Child" includes:

- (1) an Insured Person's natural child or legally adopted child;
- (2) a child placed with the Insured Person for the purpose of adoption, from:
  - (a) the moment of birth if:
    - (i) the adoption decree is entered within 31 days after the child's birth;  
or
    - (ii) the adoption proceeding is instituted within 31 days after the child's birth and the Insured Person has temporary custody of the child; or
  - (b) the date the Insured Person acquires temporary custody of the child; if the adoption proceeding is instituted more than 31 days after the child's birth;
- (3) a child for whom the Insured Person is required by court order to provide Accident insurance;
- (4) a stepchild or grandchild who resides in the Insured Person's household; and who is chiefly dependent on the Insured Person for support; and
- (5) a foster child:
  - (a) who resides in the Insured Person's household;
  - (b) who is chiefly dependent on the Insured Person for support; and
  - (c) for whom the Insured Person has assumed full parental responsibility and control.

**ELIGIBILITY.** An Insured Person becomes eligible to enroll for Dependent Accident Insurance on the latest of:

- (1) the date the Insured Person becomes eligible for Personal Accident Insurance;
- (2) the issue date of this Policy; or
- (3) the date the Insured Person first acquires a Dependent.

An Insured Person again becomes eligible to enroll for Dependent Accident Insurance under this Policy:

- (1) within 31 days following a qualifying Change in Family Status; or
- (2) during any Annual/Open Enrollment Period.

A Person must be insured for Personal Accident Insurance to insure his or her Dependents. Dependents to be insured by this Policy must be enrolled in the same plan of benefits as the Insured Person.

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

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

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

- (1) the date the Insured Person becomes eligible for Dependent Accident Insurance; or
- (2) the date the Insured Person makes written application for Dependent Accident Insurance and pays the required Dependent premium to the Company.

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

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

- (1) the Insured Person completes a written application; and
  - (2) the additional premium is paid to the Company;
- within 31 days of the date the Dependent is acquired.

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

**EXCEPTION FOR NEWBORN.** If an Insured Person acquires a newborn Dependent child, the child will be automatically insured for the first 31 days following birth. If the Insured Person elects not to enroll the newborn child and pay any additional premium within 31 days following birth, the newborn child's insurance will terminate.

**EXCEPTION FOR SURVIVING SPOUSE.** A surviving spouse who was covered under the Group Policyholder's prior group Accident plan on the day before this Policy took effect is eligible to continue to be covered for Dependent Accident Insurance under this Policy, provided the Group Policyholder submits the premium on behalf of the surviving spouse; and this Policy remains in force.

## **TERMINATION OF DEPENDENT ACCIDENT INSURANCE**

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

Dependent Accident Insurance will cease for all of the Insured Person's Dependents on the earliest of:

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

**SURVIVING DEPENDENTS.** If Personal Accident Insurance terminates under this Policy due to the Insured Person's death, Dependent Accident Insurance may be continued as follows.

**Surviving Spouse.** A surviving spouse may continue to be covered for Dependent Accident Insurance, provided the Group Policyholder submits the premium on behalf of the surviving spouse; and this Policy remains in force.

**Surviving Dependent Child(ren).** Dependent Accident Insurance may be continued for an Insured Person's surviving Dependent Child(ren):

- (1) for three Insurance Months; or
- (2) any longer period, if required by state or federal law;

provided the Group Policyholder submits the premium on behalf of the surviving Dependent Child(ren); and this Policy remains in force.

**REINSTATEMENT OF DEPENDENT INSURANCE** If an Insured Person reinstates his or her Personal Accident Insurance, the Insured Person may also reinstate Dependent's Accident Insurance at the same time. To do so, the Insured Person must follow the same requirements that apply in the reinstatement of the Insured Person's Personal Accident Insurance.

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

## PREMIUMS AND PREMIUM RATES

**PAYMENT OF PREMIUMS.** No insurance provided by this Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Group Policyholder is responsible for paying all premiums as they become due.

**GRACE PERIOD.** A grace period of 31 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the grace period, unless the Group Policyholder gives the Company advance written notice of termination. The Group Policyholder will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

**PREMIUM RATE CHANGE.** The Company may change any premium rate:

- (1) the date this Policy's terms are changed; or
- (2) the date the Company's liability is changed due to a change in federal, state or local law;
- (3) the date the Company's liability is changed because the Group Policyholder (or any covered division, subsidiary or affiliated company) relocates, dissolves or merges, or is added to or removed from this Policy; or
- (4) on any premium due date after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company, for all policies of like class.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 31 days' advance written notice of any increase in premium rates.

**PREMIUM AMOUNT.** The amount of premium due on each due date will be the total of the premium amounts obtained by multiplying:

- (1) each rate shown in the Premium Rate Schedule; by
- (2) the number of Insured Persons electing each rate.

For premium purposes, the effective date of any change in insurance is the first day of the Insurance Month which coincides with or follows the change. Changes will not be pro-rated daily.

### PREMIUM RATE SCHEDULE

#### Monthly Accident Rates

Select Plan

Class 1 - All Full-Time Employees

Personal Accident Only insurance	\$10.89
Personal Accident and Dependent Spouse insurance	\$15.39
Personal Accident and Dependent Children insurance	\$18.93
Personal Accident and Dependent (Spouse & Children) insurance	\$25.15

## POLICY TERMINATION

**TERMINATION BY THE COMPANY.** This Policy is issued for an indefinite term. The Policy will continue in force as long as premiums are paid when due, unless terminated for one of the following reasons:

- (1) the Group Policyholder, without good cause, fails to:
  - (a) promptly furnish any information which the Company may reasonably require; or
  - (b) perform its duties pertaining to this Policy in good faith; or
- (2) state law otherwise requires this Policy to be terminated.

To terminate this Policy, the Company must give the Group Policyholder at least 31 days' advance written notice of its intent to do so.

**TERMINATION BY GROUP POLICYHOLDER.** The Group Policyholder may terminate this Policy at any time by giving the Company advance written notice. Insurance will then terminate:

- (1) on the date the Company receives the notice; or
- (2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination.

**AUTOMATIC TERMINATION.** If any premium remains unpaid at the end of the Grace Period; then this Policy will automatically terminate, without any action on the Company's part, on the last day of the Grace Period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

**EFFECT ON INCURRED CLAIMS.** Termination of this Policy will not affect benefits otherwise payable for a claim incurred while this Policy is in force.

**EMERGENCY CARE BENEFITS**  
For Select Plan

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

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

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

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

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

**TREATMENT CARE BENEFITS**  
For Select Plan

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

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

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

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

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

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

**TREATMENT CARE BENEFITS**  
**(Continued)**  
For Select Plan

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

- (1) an Insured Person or Insured Dependent is confined in a Hospital, ICU or Alternate Care or Rehabilitative Facility as a result of a Covered Accident; and
- (2) the Insured Person has a child or children attending a Child Care Center.

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

## SPECIFIC INJURIES OR TREATMENTS For Select Plan

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

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

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

**BURNS.** The Company will pay a Burn benefit when an Insured Person or Insured Dependent sustains a 2<sup>nd</sup> or 3<sup>rd</sup> degree burn as a result of a Covered Accident. The 2<sup>nd</sup> or 3<sup>rd</sup> degree burn must be treated by a Physician within 72 hours of a Covered Accident. If the burns meet more than one of the Burn benefit classifications shown in the Schedule of Benefits, the Company will pay the single highest benefit amount. This benefit is payable once per person per Covered Accident.

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

**COMA.** The Company will pay a Coma benefit if an Insured Person or Insured Dependent has been in a Coma for 15 or more days as a result of a Covered Accident. This benefit is payable once per person per Covered Accident.

**CONCUSSION.** The Company will pay a Concussion benefit if the Insured Person or Insured Dependent sustains a concussion as a result of a Covered Accident. The concussion must be diagnosed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

**LACERATION.** The Company will pay a Laceration benefit when an Insured Person or Insured Dependent sustains a laceration as a result of a Covered Accident. The laceration must be treated by a Physician or Medical Health Professional within 72 hours of a Covered Accident. This benefit is payable:

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

per person as a result of any one Covered Accident.

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

**TENDON/LIGAMENT/ROTATOR CUFF.** The Company will pay the Tendon/Ligament/Rotator Cuff benefit when an Insured Person or Insured Dependent requires surgical repair of:

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

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

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

## **SPECIFIC INJURIES OR TREATMENTS**

**(Continued)**

For Select Plan

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

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

**TRANSITIONAL CARE BENEFITS**  
For Select Plan

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

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

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

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

**REASONABLE MODIFICATIONS.** The Company will pay a benefit for required modifications made to an Insured Person's or Insured Dependent's:

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

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

**ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS**  
For Select Plan

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

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

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

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

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

**TRANSPORTATION OF REMAINS.** The Company will pay a Transportation of Remains benefit if the Insured Person or Insured Dependent dies at least 100 miles from his or her principal place of residence as a result of a Covered Accident, and the bodily remains or ashes are returned:

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

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

A benefit payable for the transportation of an Insured Person's remains will be paid in accord with the Beneficiary provision. A benefit payable for the transportation of an Insured Dependent's remains will be paid to the Insured Person.

**SEAT BELT/HELMET.** If an Insured Person or Insured Dependent:

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

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

**COMMON DISASTER.** The Company will pay a Common Disaster benefit if both the Insured Person and Insured Dependent Spouse:

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

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

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

## LIMITATIONS AND EXCLUSIONS

For Classes 1 & 2

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

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

## **BENEFICIARY**

**PAYMENTS TO BENEFICIARY.** At the death of an Insured Person, any amount payable as a result of his or her death will be paid to the named Beneficiary who survives the Insured Person. If the Insured Person has not named a Beneficiary, or if no named Beneficiary survives the Insured Person; then payment will be made to the Insured Person's:

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

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

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

If the person who would otherwise receive payment dies:

- (1) within 15 days of the Insured Person's death; and
- (2) before the Company receives satisfactory proof of the Insured Person's death;

payment will be made as if the Insured Person had survived that person; unless other provisions have been made.

**NAMING THE BENEFICIARY.** An Insured Person's Beneficiary will be as shown on his or her enrollment form, unless changed. If this Policy replaces a group policy providing similar coverages; then an Insured Person's beneficiary named under the prior policy will be the Beneficiary under this Policy, until changed.

**CHANGING THE BENEFICIARY.** Only the Insured Person or his or her assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change with the Company at its Group Insurance Service Office prior to the Insured Person's death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

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

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

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

## CLAIM PROCEDURES FOR ACCIDENT INSURANCE

### NOTICE AND PROOF OF CLAIM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### TO WHOM PAYABLE

**Accidental Death & Dismemberment.** Benefits due to loss of the Insured Person's life will be paid in accord with the Beneficiary provision. All other benefits will be paid to the Insured Person.

**Other Accident Benefits.** Any other Accident benefits will be paid to the Insured Person; unless:

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

## CLAIM PROCEDURES FOR ACCIDENT INSURANCE (Continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CLAIM PROCEDURES FOR ACCIDENT INSURANCE**  
**(Continued)**

**Claims Subject to ERISA** (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

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

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

Such reimbursement is required whether the overpayment is due to:

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

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

**COMPANY'S DISCRETIONARY AUTHORITY.** Except for the functions that this Policy clearly reserves to the Group Policyholder, the Company has the authority to:

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

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

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

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:

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