BlueCross BlueShield of Texas

Voluntary Accident Insurance

Employee Benefit Booklet

NATION'S BEST HOLDINGS, LLC

GFZ02034-0001

Class 1-01

02/18/2021

This plan is an "employee welfare benefit plan," ("Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

This document serves to provide important information about the Plan. It is not the entire Plan document, but a summary of important information about the Plan. In addition to this summary plan description ("SPD"), ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. Your employer or Plan Administrator maintains the full Plan Document. If there is a conflict between the Plan Document and this SPD, the Plan Document controls. A copy of the Plan Document is available for review during normal working hours in the office of the Plan Administrator.

The benefits described in your Plan document are provided under a group Plan sponsored by the Employer and insured by Blue Cross and Blue Shield of Texas.

SUMMARY PLAN DESCRIPTION	
1. PLAN NAME: If different, the name by which the plan is commonly known.	Employee Welfare Plan
2. PLAN TYPE:	Welfare Benefit Plan providing a Group Accident Insurance Policy and Certificate
3. PLAN SPONSOR/EMPLOYER'S NAME AND ADDRESS: Name and address of employer sponsoring the Plan or employee organization maintaining the Plan	NATION'S BEST HOLDINGS, LLC 9330 LBJ FRWY STE 850 Dallas TX 75243
4. EMPLOYER IDENTIFICATION NUMBER (EIN): Employer identification number assigned by the IRS to the Plan Sponsor	75-1850578
5. PLAN NUMBER: Number assigned by the Plan Sponsor. This number is used for Form 5500 reporting. Each Plan should be assigned a unique number that is not used more than once.	501
6. ERISA PLAN YEAR ENDS ON EACH: This is the end of the Plan Year for maintaining the Plan's fiscal records and may be different from the insurance policy year.	02/28
7. PLAN ADMINISTRATOR'S NAME, ADDRESS, AND TELEPHONE NUMBER:	NATION'S BEST HOLDINGS, LLC 9330 LBJ FRWY STE 850 Dallas TX 75243 903-887-7581
8. AGENT FOR SERVICE OF LEGAL PROCESS ON THE PLAN:	
9. SOURCES OF FUNDING AND CONTRIBUTIONS: Contributions are, for example, employer, employee organization or employee contributions and the method by which the amount of the contributions is calculated. Funding is the medium by which the Plan is funded. For example, the identity of the insurance company or trust fund through which the Plan is funded or benefits are provided.	The Plan is funded as an insured plan under policy number GFZ02034 issued by Blue Cross and Blue Shield of Texas. Contributions to the Plan are made as stated on the Schedule of Benefits in the Group Insurance Certificate. The employer determines the method of funding and contributions, if any, to be made by the participants.

10. TYPE OF ADMINISTRATION:	This plan is administrated by insurer administration.
11. CLAIM ADMINISTRATION:	The Claim Administrator is not the "plan administrator" of your Plan, as defined in Section 3(16)(A) of ERISA. The Plan Administrator has selected Blue Cross and Blue Shield of Texas as the claims administrator of your Plan and has delegated to Blue Cross and Blue Shield of Texas the authority and discretion to administer the terms of the applicable group policy provisions such as making initial claim determinations concerning the availability of benefits, and the final review and benefit determinations for appealed claims.
12. EACH TRUSTEE'S NAME, TITLE, AND ADDRESS OF PRINCIPAL PLACE OF BUSINESS: This is only applicable if the Plan has trustees.	
13. LABOR ORGANIZATION: This is applicable if the Plan is subject to a CBA.	
14. PLAN AMENDMENT AND TERMINATION PROCEDURE:	The Employer reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan (including any related documents and underlying policies), in whole or in part, at any time, without prior notice. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan. The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures. Rights with respect to termination of insurance benefits are stated in the Policy and Certificate. The employer can request a Policy change, including a change to benefits, rights and obligations under the Policy but only an officer of Blue Cross and Blue Shield of Texas can approve a change to the Policy. The change must be in writing and endorsed on or attached to the Policy
15. ELIGIBILITY FOR PARTICIPATION AND BENEFITS:	These requirements are found in the Policy and Certificate incorporated herein by reference.
16. CIRCUMSTANCES CONCERNING INELIGIBILITY, DISQUALIFICATION, OR DENIAL OR LOSS OF BENEFITS:	These requirements are found in the Policy and Certificate incorporated herein by reference.
17. CLAIMS PROCEDURES: The procedures which govern claims for benefits and requests for review of denied claims.	The Plan's claims procedures are furnished automatically, without charge, as a separate document. Refer to the ERISA Information Statement incorporated herein by reference.

Dearborn Life Insurance Company

(A stock life insurance company, herein called "*We*" "*Us*" or "*Our*")

Administrative Office:
701 E. 22nd Street
Lombard, IL 60148

Having issued Group Policy No. GFZ02034

(herein called the *Policy*)

to

NATION'S BEST HOLDINGS, LLC
(herein called the *Policyholder*)

GROUP ACCIDENT INSURANCE CERTIFICATE

CERTIFIES that *You* are insured, if *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, and remain insured in accordance with the terms of the *Policy*. *Your* insurance is subject to all the definitions, exclusions, limitations and conditions of the *Policy*, and it takes effect as stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This *Certificate* describes *Your* eligibility for benefits and the terms and provisions of the *Policy*. It replaces and cancels any other *Certificate* previously issued to *You* under the *Policy*.

If the terms and provisions of this Group Insurance *Certificate* (issued to *You*) are different from the *Policy* (issued to the *Policyholder*), the *Policy* will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the *Policy.*

READ THIS CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

Secretary

President

Voluntary Group Accident Insurance Certificate
with Dependent Accident Benefits
Non-Participating

THIS IS AN ACCIDENT ONLY CERTIFICATE

THIS IS NOT A WORKERS' COMPENSATION POLICY

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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SCHEDULE OF BENEFITS

POLICYHOLDER:	NATION'S BEST HOLDINGS, LLC
POLICY NUMBER:	GFZ02034
POLICY EFFECTIVE DATE:	03/01/2021
ANNUAL ENROLLMENT PERIOD:	February 18 - February 27

ELIGIBILITY: All full-time Employees of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Eligibility Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 30 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.

Eligibility Waiting Period:

Current *Employees*: First of the month following 2 Months of continuous, full-time Active Work

New *Employees*: First of the month following 2 Months of continuous, full-time Active Work

Policyholder Contribution: *Voluntary Accident* 0% of premium

Coverage For: *Employee, Spouse, and Dependent Child*

Dependent Benefit amounts unless otherwise stated:

Spouse Benefits	100% of the *Employee's* benefit amount
Dependent Child Benefits Live birth to age 26	100% of the *Employee's* benefit amount

Coverage Type: Group Accident Insurance Off the job coverage.

Reduction of Benefits: Benefits terminate at age 70, or retirement whichever comes first.

Portability:

Benefit Eligibility	Voluntary
Insured Eligibility	*Employee, Spouse, Dependent Child(ren)*
Portability Benefit Duration	To Age 65

Accident Insurance Benefits

Emergency Treatment Benefits

Accident Emergency Treatment Benefit	
Emergency Room	$150
Urgent Care Center	$150
Physician's Office	$50
X-Ray Benefit	$50
Accident Follow-Up Treatment Benefit	$50
Hospital Admission Benefit	$1,200
Intensive Care Unit (ICU) Admission Benefit	$2,000
Hospital Confinement Benefit	$250
Intensive Care Unit (ICU) Confinement Benefit	$500

Accident Injury Benefits

Dislocation Benefit	**Open Reduction**	**Closed Reduction**
Hip	$4,000	$1,500
Knee	$2,000	$1,500
Shoulder	$2,000	$1,500
Collar bone	$1,700	$500
Ankle or foot (excluding toes)	$1,500	$500
Lower jaw	$1,000	$500
Wrist	$750	$500
Elbow	$750	$500
Toe	$300	$100
Finger	$300	$100
Local or no anesthesia (percent of closed reduction)		25%

Burn Benefit

Square Centimeters of the body surface burned	2nd Degree Burn	3rd Degree Burn
Less than 20	$125	$250
At least 20 but less than 40	$250	$625

At least 40 but less than 65	$500	$1,250
At least 65 but less than 160	$750	$3,750
At least 160 but less than 225	$1,000	$8,750
225 or more	$1,250	$12,500
Skin Graft Benefit as percentage of Burn Benefit	50%	50%
Eye Injury Benefit		
Surgical Repair		$300
Removal of foreign body		$65
Laceration Benefit		
Laceration with no repair		$35
Total of all lacerations with repair:		
Less than 5 cm		$65
5 cm – 15 cm		$250
Greater than 15 cm		$500
Fracture Benefit	**Open Reduction**	**Closed Reduction**
Hip	$5,000	$2,000
Leg	$3,000	$1,000
Hand (excluding fingers)	$1,500	$500
Foot (excluding toes/heel)	$1,500	$500
Wrist	$1,500	$500
Elbow	$1,500	$500
Ankle	$1,500	$500
Kneecap	$1,500	$500
Shoulder blade	$1,500	$500
Forearm	$1,500	$500
Lower jaw	$1,500	$500
Vertebrae (body of)	$2,000	$700
Pelvis	$2,000	$700
Sternum	$2,000	$700
Upper jaw or face (excluding nose)	$1,200	$375
Upper arm	$1,200	$375

Rib	$2,200	$500
Nose	$1,000	$250
Heel	$1,000	$250
Finger	$1,000	$250
Coccyx	$500	$250
Toes	$500	$250
Vertebral Processes	$3,000	$400
Skull - depressed	$3,500	$1,875
Skull - simple	$1,800	$800
Chip Fracture (% of Closed Reduction)		25%
Concussion Benefit		$150
Dental Benefit		
Broken tooth repaired with crown		$400
Broken tooth resulting in extraction		$130
Coma Benefit		$12,500
Paralysis Benefit		
Quadriplegia		$12,500
Paraplegia		$6,250
Hemiplegia		$4,750

Surgical Benefits

Surgical Procedure Benefit	
Arthroscopy	$300
Open abdominal	$1,250
Cranial	$1,250
Hernia	$1,250
Thoracic Surgery	$1,250
Repair of Tendon and/or Ligament	$625
Repair of Torn Rotator Cuff	$625
Repair of Ruptured Disc	$625
Repair of Torn Knee Cartilage	$625
Miscellaneous Surgical Procedure Benefit	
Surgery with General Anesthesia	$300

Surgery with Conscious Sedation		$120
Outpatient Ambulatory Surgical Center Benefit		
Increase to applicable Surgical or Miscellaneous Surgical benefit		20%

Additional Accident Benefits

Major Diagnostic Exam Benefits		$200
Epidural Pain Management Benefit		$100
Physical Therapy Benefit		$35
Rehabilitation Unit Benefit		$150
Appliance Benefit		$125
Prosthesis Benefit		
One prosthetic device		$750
More than one prosthetic device		$1,500
Blood/Plasma/Platelets Benefit		$200
Ambulance Benefit		
Ground Ambulance		$200
Air Ambulance		$1,500
Transportation Benefit		$600
Lodging Benefit		$125

Accidental Death and Dismemberment Benefits

Accidental Death Benefit		
	Employee	$40,000
	Spouse	$40,000
	Child(ren)	$12,500
Accidental Death Common Carrier Benefit		
	Employee	$150,000
	Spouse	$150,000
	Child(ren)	$25,000
Accidental Dismemberment Benefit		
Loss of both arms and both legs	*Employee*	$40,000
	Spouse	$40,000
	Child(ren)	$12,500

Loss of both eyes, or both feet or, both hands, or both arms or both legs	*Employee*	$40,000
	Spouse	$40,000
	Child(ren)	$12,500
Loss of one eye, or one foot, or one hand, or one arm or one leg	*Employee*	$10,000
	Spouse	$10,000
	Child(ren)	$3,750
Loss of one or more fingers and/ or one or more toes	*Employee*	$2,000
	Spouse	$2,000
	Child(ren)	$625

Wellness Benefit

Wellness Benefit	$50 per *Calendar Year* per *Covered Person*

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

The eligibility for this insurance is as indicated in the Schedule of Benefits.

The *Eligibility Waiting Period* is further defined in the Schedule of Benefits.
00001

When does Your Contributory insurance become effective?

You may enroll for coverage during the *Annual Enrollment Period*, unless *You* qualify because of a *Change in Family Status*. *Your Contributory* coverage will become effective on the latest of the following dates:

1. If *You* enroll for coverage prior to the *Policy Effective Date*, the *Policy Effective Date*; or
2. If *You* enroll for coverage after the *Policy Effective Date* on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*; or
3. If *You* enroll during an *Annual Enrollment Period*, the next *Anniversary Date* following the *Annual Enrollment Period*.

Coverage requested because of a *Change in Family Status* will become effective on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*.
00003

Change in Family Status

If *You* experience a *Change in Family Status*, *You* may enroll for coverage, apply for additional coverage, or request changes to *Your* current insurance coverage, provided the change is consistent with the *Change in Family Status.* For *Your* coverage to become effective, *We* must receive a completed *Enrollment Form* within 31 days of the *Change in Family Status*.

Change in Family Status means:

1. *You* get married or execute a domestic partner affidavit; or
2. *You* have a *Dependent Child*, or *You* adopt or become the legal guardian of a *Dependent Child*; or
3. *Your Spouse* dies or *You* become divorced; or
4. *Your Dependent Child* becomes emancipated or dies; or
5. *Your Spouse* is no longer employed, resulting in a loss of group insurance; or
6. *You* have a change in employment classification which results in *You* changing from part-time to full-time, or full-time to part-time employment.

00004A

When does Dependent coverage become effective?

Your Dependent's coverage will become effective on the latest of:
1. The date *Your* coverage becomes effective under the *Policy*, if *You* have enrolled for *Dependent* coverage on or before that date; or
2. The first day of the month following the date *You* enroll for *Dependent* coverage.

When does coverage for a new Spouse become effective?

Coverage for a new *Spouse* starts automatically on *Your* marriage. *Your* new *Spouse* will be a *Covered Person* for 31 days. *Your Spouse* will cease to be a *Covered Person* unless:
1. *You* request, in writing within those 31 days continuation of such *Dependent* coverage; and
2. The required premium is paid. Premium will be charged from the date of marriage.

When does coverage for a newborn Child become effective?

If *You* have not previously elected *Dependent Child* coverage, coverage for a newborn *Child* starts automatically from the moment of birth if a *Child* is born to *You.* The newborn *Child* will be a *Covered Person* for 31 days. The newborn *Child* will cease to be a *Covered Person* after 31 days, unless:

1. *You* request in writing within those 31 days continuation of such *Dependent Child* coverage; and
2. The required premium is paid. Premium will be charged from the date of birth.

If *You* currently have *Dependent Child* coverage, *Your* newborn *Child* will be automatically added to *Your* coverage.

Dependent Child coverage will also be extended to newly adopted, foster or step *Children*, as of the date they become financially dependent on *You* for support, provided they otherwise meet the definition of a *Dependent Child*.
00005

What is an Annual Enrollment Period?

Unless otherwise specified, *Annual Enrollment Period* means a period of time during which *Employees* may enroll for coverage or request changes to their benefit plan. The *Annual Enrollment Period* is shown on the *Schedule of Benefits*.

Initial requests for coverage or requests for changes to existing coverage made during the *Annual Enrollment Period* will become effective on the next *Policy Anniversary Date*.
00007

Eligibility after You Terminate Employment

If *Your* coverage ends due to termination of employment and *You* do not elect continued coverage under the Portability Benefit provision, *You* must meet all the requirements of a new *Employee* if *You* are rehired by the *Policyholder* at a later date.
00009

Changes to Your coverage

A change in *Your* coverage may occur if:

1. *You* enroll for a different benefit amount; or
2. there is a *Policy* change; or
3. *You* enter another class and become eligible for a change in benefits.

If *You* are eligible for additional coverage due to a *Policy* change, the additional coverage will be effective on the date the *Policy* change is effective, as requested by the *Policyholder* and agreed upon by *Us*.

If a change results in additional coverage, for reasons other than a *Policy* change, the change will be effective the first of the month following the later of:

1. The date *You* enroll for the additional coverage; or
2. The date *You* become eligible for the additional coverage, if enrollment is not required.

Additional *Contributory* coverage is subject to *Our receipt of premium.*

If a change results in a decrease in coverage the change will take effect immediately.
00010

ACCIDENT INSURANCE BENEFITS

Emergency Treatment Benefits

What is the Accident Emergency Treatment Benefit?

The Accident Emergency Treatment Benefit is payable if a *Covered Person* receives treatment for an *Injury*. For purposes of this benefit, ***Accident Emergency Treatment*** means treatment received in a *Hospital Emergency Room*, or *Urgent Care Center* or a *Physician's* office within 72 hours of the *Accident*. This benefit is payable once per *Accident*, per *Covered Person*.

We will pay either the *Hospital Emergency Room* benefit, or *Urgent Care Center* benefit or *Physician's* office benefit. If treatment is received at more than one location, *We* will pay the highest level benefit.
00011

What is the X-Ray Benefit?

The X-Ray Benefit is payable if a *Covered Person* receives an x-ray while receiving emergency treatment for an *Injury*. The x-ray must be taken within 72 hours of the *Accident*. This benefit is limited to one payment per *Accident*, per *Covered Person*. The X-Ray Benefit is not payable for exams listed in the Major Diagnostic Exams Benefit.
00012

What is the Accident Follow-up Treatment Benefit?

The Accident Follow-up Treatment Benefit is payable if a *Covered Person* receives emergency treatment for an *Injury* and later requires additional treatment for an *Injury* sustained in the same *Accident*, over and above emergency treatment administered in the first 72 hours following the *Accident*. *We* will pay for one treatment per day for up to 6 treatments per *Accident*, per *Covered Person*. The treatment must begin within 30 days of the *Accident* or discharge from the *Hospital*. Treatments must be furnished by a *Physician* in a *Physician's* office or in a *Hospital* on an outpatient basis. The Accident Follow-up Benefit is not payable for the same days that the Physical Therapy Benefit is paid.
00013

What is the Hospital Admission Benefit?

The Hospital Admission Benefit is payable if a *Covered Person* is admitted for a *Hospital Confinement* of at least 18 hours for treatment of an *Injury*. This benefit is payable only once per *Hospital Confinement* and only once per *Accident*, per *Covered Person*. *Hospital Confinements* must start within 30 days of the *Accident*.

We will only pay the Hospital Admission Benefit or the Intensive Care Unit Admission Benefit. *We* will not pay both benefits for a *Covered Person* for the same *Accident*.
00014

What is the Intensive Care Unit (ICU) Admission Benefit?

The ICU Admission Benefit is payable if a *Covered Person* is admitted directly to an *ICU* of a *Hospital* for at least 18 hours of treatment for an *Injury*. This benefit is payable only once per period of *Hospital Confinement* and only once per *Accident*, per *Covered Person*. The *ICU* confinement must start within 30 days of the *Accident*.

We will only pay the Hospital Admission Benefit or the Intensive Care Unit Admission Benefit. *We* will not pay both benefits for a *Covered Person* for the same *Accident*.
00015

What is the Hospital Confinement Benefit?

The Hospital Confinement Benefit is payable if a *Covered Person* is admitted for a *Hospital Confinement* of at least 18 hours for treatment of an *Injury*. *We* will pay this benefit up to 365 days per *Accident*, per *Covered Person*. *Hospital Confinements* must start within 30 days of the *Accident*. The Hospital Confinement Benefit and the Rehabilitation Unit Benefit are not paid for the same date of service. The highest eligible benefit will be paid.

If a *Covered Person* is confined in an *ICU* for more than 15 days, *We* will pay the Hospital Confinement Benefit beginning on the 16th day. The total amount payable per *Accident* will not exceed 365 days for *Hospital Confinement* and 15 days for *ICU*. *We* will not pay both benefits for the same date of service.
00016

What is the Intensive Care Unit (ICU) Confinement Benefit?

The Intensive Care Unit Confinement Benefit is payable if a *Covered Person* is confined to a *Hospital Intensive Care Unit* for treatment of an *Injury*. This Intensive Care Unit Confinement Benefit is payable for up to 15 days per *Accident*, per *Covered Person*. *ICU* confinement must start within 30 days of the *Accident*.

If a *Covered Person* is confined in an *ICU* for more than 15 days, *We* will pay the Hospital Confinement Benefit beginning on the 16th day. The total amount payable per *Accident* will not exceed 365 days for *Hospital Confinement* and 15 days for *ICU*. *We* will not pay both benefits for the same date of service.
00017

Accident Injury Benefits

What are the Accident Injury Benefits?

The Accident Injury Benefits are payable when a *Covered Person* receives treatment for an *Injury* sustained in an *Accident*.
00018

Dislocation Benefit:

The Dislocation Benefit is payable for a *Covered Person* who sustains a *Dislocation* as the result of an *Injury*. The *Dislocation* must be diagnosed by a *Physician* within 90 days after the date of the *Accident.* The treatment of the *Dislocation* must require anesthesia by a *Physician*. It can be corrected by open (surgical) or closed (non-surgical) *Reduction*. The applicable amount payable is listed in the Schedule of Benefits.

We will pay for no more than two *Dislocations* per *Accident*, per *Covered Person*. *We* will pay for the first *Dislocation* of any individual joint per *Accident*.
00019

Burn Benefit

The Burn Benefit is payable for a *Covered Person* who sustains burns as the result of *Injuries* received in an *Accident*. The *Covered Person* must be treated by a *Physician* within 72 hours after the *Accident*. If the *Covered Person* meets more than one of the burn classifications, as shown in the Schedule of Benefits, *We* will pay for only one burn at the highest amount. *We* will pay this benefit once per *Covered Person* per *Accident*. The applicable amount payable is listed on the Schedule of Benefits.
00020

Skin Graft Benefit

The Skin Graft Benefit is payable for a *Covered Person* who receives a skin graft for a burn for which a benefit was received under the Burn Benefit. This benefit is not payable for elective procedures and/or cosmetic surgery that are not the result of the *Accident*. This benefit is payable once per *Covered Person* per *Accident*.
00021

Eye Injury Benefit

The Eye Injury Benefit is payable for a *Covered Person* who requires eye surgery or the removal of a foreign object from the eye by a *Physician* as a result of an *Injury*. The surgery or the removal must occur within 90 days after the date of the *Accident*. This benefit is payable once per *Covered Person* per *Accident*.
00022

Laceration Benefit

The Laceration Benefit is payable for a *Covered Person* who sustains *Lacerations* as the result of an *Injury*. A *Laceration* is a cut. The *Laceration* must be repaired by a *Physician* within 72 hours after the *Accident*. *We* will pay the applicable amount listed on the Schedule of Benefits. The benefit payable will be based on the total length of all *Lacerations* received in any one *Accident* which require repair. If the *Laceration* is severe enough to require stitches but the *Physician* chooses to repair it another way, *We* will pay it as if the *Laceration* was repaired with stitches.

If a *Covered Person* sustains a *Laceration* on a finger, toe, hand, foot or eye and later loses that finger, toe, hand, foot or eye as a result of the same *Accident, We* will subtract the amount *We* paid under the Laceration Benefit from the Accidental Dismemberment Benefit for loss of Finger, Toe, Hand, Foot or Eye benefit.
00023

Fracture Benefit

The Fracture Benefit is payable for a *Covered Person* who sustains a *Fracture* as the result of an *Injury*. The *Fracture* must be diagnosed by a *Physician* within 14 days after the *Accident* and must require open (surgical) or closed (non-surgical) *Reduction* by a *Physician*. The applicable amount payable is listed on the Schedule of Benefits.

We will pay no more than one Fracture Benefit per bone, per *Accident*.

If multiple bones are *Fractured* in an *Accident*, *We* will pay no more than two times the highest Fracture Benefit that would otherwise be payable for any one of the bones involved.

We will pay the benefit amount shown in the Schedule of Benefits for the closed *Reduction* for *Chip Fractures*.
00024

Concussion Benefit

The Concussion Benefit is payable for a *Covered Person* who sustains a concussion as the result of an *Injury*. The *Covered Person* must be diagnosed by a *Physician* within 72 hours after the date of the *Accident* using any type of medical imaging procedures. This benefit is payable once per *Covered Person* per *Accident*.
00025

Dental Benefit

The Dental Benefit is payable for a *Covered Person* who requires dental work as the result of an *Injury*. This benefit is payable for newly broken teeth repaired with a crown or resulting in extraction. The dental services must begin within 60 days of the *Accident*. *We* will pay for no more than one crown and one extraction per *Accident*, per *Covered Person*, regardless of the number of teeth involved.
00026

Coma Benefit

The Coma Benefit is payable for a *Covered Person* who sustains a *Coma* as the result of an *Injury*. The *Coma* must occur within 14 days of the *Accident* and last for a period of seven or more consecutive days. Medically induced *Comas* are not covered under the Coma Benefit. For the purpose of this benefit, ***Coma*** means a continuous state of profound unconsciousness characterized by the absence of purposeful response to commands, including:

- Eye opening;
- Verbal responses; and
- Motor responses.

The *Coma* must require intubation for respiratory assistance.
00027

Paralysis Benefit

The Paralysis Benefit is payable for a *Covered Person* who becomes *Paralyzed* as a result of spinal cord *Injuries* sustained in an *Accident*. The *Paralysis* must be confirmed by a *Physician* and be continuous for a period of at least 30 days. The Paralysis Benefit is listed in the Schedule of Benefits and will be paid according to the number of paralyzed limbs. This benefit will be payable once per *Covered Person*.
00028

Surgical Benefits

Surgical Procedure Benefit

The Surgical Procedure Benefit is payable for a surgery performed within 180 days of an *Accident* which resulted in an *Injury*. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the surgery with the highest benefit amount. The covered surgeries are listed in the Schedule of Benefits.
00029

Miscellaneous Surgical Procedure Benefit

The Miscellaneous Surgical Procedures Benefit is payable for any other surgery to a *Covered Person* as the result of an *Injury* sustained in an *Accident* that is not covered by any other surgical benefit. The surgery must be performed within 180 days of the *Accident*. Only one Miscellaneous Surgical Procedures Benefit is payable per 24-hour period even though more than one surgical procedures may be performed.
00030

Outpatient Ambulatory Surgical Center Benefit

The Outpatient Ambulatory Surgical Center Benefit is payable when a *Covered Person* undergoes a surgery listed in the Surgical Procedures Benefit or the Miscellaneous Surgical Procedures Benefit and the surgery is performed at an *Outpatient Ambulatory Surgical Center*. The Outpatient Surgical Center benefit will increase the Surgical Procedures Benefit or Miscellaneous Surgical Procedures Benefit payable by the amount listed in the Schedule of Benefits.
00031

Additional Accident Benefits

What is the Major Diagnostic Exams Benefit?

The Major Diagnostic Exams Benefit is payable when a *Covered Person* requires one of the following exams for an *Injury*: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a *Hospital* or a *Physician's* office and performed within 90 days of the *Accident*. This benefit is limited to one payment per *Accident*. Exams listed in the Major Diagnostic Exams Benefit are not payable under the X-Ray Benefit.
00032

What is the Epidural Pain Management Benefit?

The Epidural Pain Management Benefit is payable when a *Covered Person* receives an epidural administered for pain management in a *Hospital* or a *Physician's* office for an *Injury*. The epidural anesthesia must be administered within 60 days after the *Accident*. This benefit is not payable for an epidural administered during a surgical procedure. This benefit is payable no more than once per covered *Accident*, per *Covered Person*.
00033

What is the Physical Therapy Benefit?

The Physical Therapy Benefit is payable when a *Covered Person* receives emergency treatment for an *Injury* and later receives physical therapy from a licensed *Physical Therapist*. The physical therapy must be on the advice of a *Physician*. Physical therapy must be for *Injuries* sustained in an *Accident* and must start within 30 days of the *Accident* or discharge from a *Hospital Confinement* due to an *Injury*. *We* will pay for one treatment per day for up to a maximum of ten treatments per *Accident*, per *Covered Person*. The treatment must be completed within six months after the *Accident*. The Physical Therapy Benefit is not payable for the same days that the Accident Follow-Up Treatment Benefit is paid.
00034

What is the Rehabilitation Unit Benefit?

The Rehabilitation Unit Benefit is payable when a *Covered Person* is admitted for a *Hospital Confinement* and is immediately transferred to a bed in a *Rehabilitation Unit* of a *Hospital* for treatment of an *Injury*. This benefit is limited to 30 days for each *Covered Person* per *Accident*. The Rehabilitation Unit Benefit will not be payable for the same days the Hospital Confinement Benefit is paid. The highest eligible benefit will be paid.
00035

What is the Appliance Benefit?

The Appliance Benefit is payable when a *Covered Person* receives a medical appliance, prescribed by a *Physician*, as an aid in personal locomotion, for an *Injury*. The appliance must be prescribed by a *Physician* within 90 days after the date of the *Accident*. Benefits are payable for the following types of appliances: wheelchair, cane, leg brace, back brace, walker, and a pair of crutches. This benefit is payable once per *Accident*, per *Covered Person*.
00036

What is the Prosthesis Benefit?

The Prosthesis Benefit is payable when a *Covered Person* requires use of one or more *Prosthetic Devices* as a result of an *Injury*. The prosthetic(s) must be prescribed by a *Physician* and received within 365 days of the *Accident*. This benefit is not payable for repair or replacement of existing *Prosthetic Devices*, even if the *Prosthetic Device* is damaged as a result of the *Accident*. *Prosthetic Devices* do not include hearing aids, wigs, or dental aids to include false teeth. *We* will not pay this benefit for a joint replacement. This benefit is payable once per *Accident*, per *Covered Person*.
00037

What is the Blood/Plasma/Platelets Benefit?

The Blood/Plasma/Platelets Benefit is payable when a *Covered Person* receives blood/plasma and/or platelets for the treatment of an *Injury*. The blood/plasma and/or platelets must be administered within 90 days of the *Accident*. This benefit does not pay for immunoglobulins. It is payable only one time per *Accident*, per *Covered Person*.
00038

What is the Ambulance Benefit?

The Ambulance Benefit is payable when a *Covered Person* requires ambulance transportation to a *Hospital* for an *Injury*. Ambulance transportation must be within 72 hours of the *Accident*. A licensed professional ambulance company must provide the ambulance service.
00039

What is the Transportation Benefit?

The Transportation Benefit is payable when a *Covered Person* requires transportation from his residence to a facility for medical treatment due to an *Injury* sustained in an *Accident*. The location of the treatment must be on the advice of the local *Physician* for a *Hospital Confinement*, outpatient surgery or a *Physician's* office visit.

This benefit is not payable for transportation when the facility is located within a 50-mile radius of the residence of the *Covered Person* or for transportation by ambulance or air ambulance. This benefit is payable for up to three round trips per *Accident*, per *Covered Person*.

We will also pay a Transportation Benefit for a companion to travel commercially (plane, train or bus) if accompanying a covered *Dependent Child* who requires medical treatment due to an *Injury* sustained in an *Accident*.
00040

What is the Lodging Benefit?

The Lodging Benefit is payable if a companion accompanies a *Covered Person* who is admitted for a *Hospital Confinement* for the treatment of an *Injury* and requires overnight lodging. This benefit is payable only for the same period of time the injured *Covered Person* is confined to the *Hospital*. The *Hospital* and lodge motel/hotel must be more than 50 miles from the residence of the *Covered Person*. This benefit is limited to one lodge room per night and is payable up to 30 days per covered *Accident*. The companion must incur an expense for the lodging.

For the purposes of this benefit, ***Lodging*** means an establishment licensed under the laws where it is located, such as a motel, hotel or other facility that provides sleeping accommodations to the general public in exchange for a fee.
00041

ACCIDENTAL DEATH and DISMEMBERMENT BENEFITS

What is the Accidental Death Benefit?

The Accidental Death Benefit is payable if a *Covered Person* dies within 90 days of the date of an *Accident* as a result of *Injuries* received from that *Accident*. If *We* pay this benefit for a *Covered Person*, *We* will not pay the Accidental Death Common Carrier Benefit for the same *Covered Person*.
00044

What is the Accidental Death Common Carrier Benefit?

The Accidental Death Common Carrier Benefit is payable if a *Covered Person* dies within 90 days of the date of an *Accident* as a result of *Injuries* received from that *Accident*, while a fare paying passenger on a *Common Carrier*.

A ***Common Carrier*** means commercial airplanes, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points. A *Common Carrier* operates under a license to transport passengers for hire. A *Common Carrier* does not include private, on demand, or chartered transportation in which a *Covered Person* is a passenger at the time of the *Accident*.

If *We* pay this benefit for a *Covered Person*, *We* will not pay the Accidental Death Benefit for the same *Covered Person*.
00045

What is the Accidental Dismemberment Benefit?

The Accidental Dismemberment Benefit is payable if a *Covered Person* suffers a loss listed in the Schedule of Benefits due to *Injuries* sustained in an *Accident*. The loss must occur within 90 days of the *Accident*. *We* will pay only one loss and the highest single benefit per *Covered Person* for *Dismemberment*. Benefits will be paid only once per *Covered Person*, per *Accident*. If death and *Dismemberment* result from the same *Accident*, *We* will pay only the applicable Accidental Death Benefit.
00047

WELLNESS BENEFIT

What is the Wellness Benefit?

If, while insured under the *Policy*, a *Covered Person* undergoes any of the *Wellness Tests* indicated below, *We* will pay the amount as set forth in the Schedule of Benefits.

Wellness Tests include:

- Blood test for triglycerides;
- Bone marrow aspiration or biopsy;
- CA 15-3 (blood test for breast cancer);
- CA-125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Carotid Doppler;
- Chest x-ray;
- Colonoscopy;
- Echocardiogram;
- Electrocardiogram;
- Fasting blood glucose test;
- Fasting plasma glucose (FPG);
- Flexible sigmoidoscopy;
- Hemoglobin A1C (HbA1c);
- Hemocult stool analysis;
- Mammography;
- Pap smear;
- PSA (blood test for prostate cancer);
- Serum cholesterol test to determine HDL and LDL levels;
- Serum protein electrophoresis (blood test for myeloma);
- Skin cancer biopsy;
- Stress test on a bicycle or treadmill;
- Thermography;
- Thin prep pap test;
- Two hour post-load plasma glucose; or
- Virtual colonoscopy.

The *Wellness Benefit* is payable once per *Calendar Year* for each *Covered Person*.

Calendar Year means the period beginning January 1st and ending December 31st.

The *Wellness Tests* must be performed while the *Covered Person's* coverage under the *Policy* is in force. *Proof* must be provided that the test was performed.
00055

LIMITATIONS AND EXCLUSIONS

Limitations*:*

In additions to the limitations and exclusions listed in the individual benefits, *We* will not pay any benefit for an *Injury* resulting from or caused by:

1. any disease, *Illness* or infirmity of mind or body, and any medical or surgical treatment thereof; or
2. any error, mishap or malpractice during a medical, diagnostic or surgical treatment or procedure for any *Illness*; or
3. cosmetic surgery or other elective procedure that is not medically necessary; or
4. any *Injury* or treatment which is covered by a Workers' Compensation or occupational disease law; or
5. suicide or attempted suicide, while sane or insane; or
6. any intentionally self-inflicted *Injury*; or
7. war, declared or undeclared, whether or not a member of any armed forces; or
8. travel or flight in any aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
9. commission of, participation in, or an attempt to commit an assault or felony as defined by state or federal law; or
10. The *Covered Person* being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a *Physician* and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
11. The *Covered Person* being intoxicated as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated; or
12. active participation in a *Riot*. ***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder; or
13. driving or riding in any vehicle used in a race, speed or endurance test or for acrobatic or stunt driving; or
14. an occupational *Accident.*

Exclusions:

We will not pay any benefits for an *Accident* that occurred while the *Covered Person* was operating a motor vehicle and was either:

1. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a *Physician* and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
2. intoxicated as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if such jurisdiction does not define intoxication. Conviction is not necessary for a determination of being intoxicated.

00056

PORTABILITY BENEFIT

What is the Portability Benefit?

If *Your Voluntary* group *Accident Insurance* terminates, *You* may elect to continue *Your* insurance in accordance with the terms of the *Policy* by paying premiums directly to *Us*. If *You* elect Portability, *You* may also elect to continue *Dependent* coverage under the conditions set forth below, but *You* may not enroll for *Dependent* coverage at the time *You* elect Portability. The coverages eligible for Portability and the Portability Benefit Duration are in the Schedule of Benefits.

The premiums for the coverage continued under the Portability Benefit will not be the same as the premium *You* are charged for *Your* group insurance under the *Policy*. Portability premium will be based on:
1. *Our* current rates for the applicant's age and class of risk at the time he elects Portability; and
2. the amount of insurance continued under Portability.

The maximum amount of insurance which may be continued under Portability is the amount of insurance *You* had in force under the *Policy* at the time the Portability Benefit is elected, not to exceed the Portability Benefit amount as set forth in the Schedule of Benefits.

What are Eligibility Requirements for Employee Portability?

To be eligible for Portability, *You* must meet the following conditions:
1. *You* must have been insured under the *Policy* or the *Policy* it replaced for at least one year prior to electing Portability; and
2. *Your* insurance, or a portion of it, must have terminated for reasons other than *Illness, Injury*, retirement or termination of the *Policy*; and
3. *You* must be less than 60 years of age.

You must submit a *Portability Request Form* and the first premium within 31 days after the date *Your* insurance terminated.

We reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* intentionally misrepresented a material fact in the *Portability Request Form*.

Can Dependent Insurance be Ported if Your Eligibility Terminates or if Your Spouse's Coverage Terminates?

If *Dependent* coverage ceases, *You* or *Your* covered *Spouse* may elect Portability of *Dependent* coverage as follows:
1. *You* may elect Portability of *Dependent* coverage if *You* meet the eligibility requirements to port *Your* insurance as shown above and *You* are covered for *Dependent* coverage on the date *Your* coverage ceases.
2. *Your Spouse* may elect Portability of his group insurance, and/or insurance on covered *Dependent Child(ren)* if:
    a. *Your Spouse'*s insurance terminates because *You* die or *Your* eligibility for *Dependent* coverage ceases for reasons other than retirement or termination of the *Policy* and *Your Spouse* is less than 60 years of age, and
    b. *Your Spouse* had elected *Dependent* coverage on *Eligible Dependent Child(ren)* and such coverage is still in force when *Your* eligibility for *Dependent* coverage ceased for reasons other than retirement or termination of the *Policy*.

Your Spouse must have been insured for such coverage(s) under the *Policy* for at least one year prior to electing Portability.

Exception: Portability is not available if *Your Spouse's* insurance terminates because he no longer meets the *Policy* definition of a *Dependent Spouse*.

If these criteria are met, *You* or *Your Spouse*, must submit a *Portability Request Form* and pay the first premium within 31 days after the date such *Dependent* coverage terminated.

We reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* or *Your Spouse* intentionally misrepresented a material fact in the *Portability Request Form*.

A ***Portability Request Form*** means a form acceptable to *Us* which *You* complete and submit to elect coverage under the Portability Benefit.

When will Portable Coverage Terminate?

Coverage continued under the Portability Benefit will terminate at the earliest of the following:

1. the date *You* return to *Active Work* with the *Policyholder* while the *Policy* is still in force; or
2. the date required premiums are not paid when due; or
3. the end of the Portability Benefit Duration in the Schedule of Benefits; or
4. the premium due date following the date a *Dependent* ceases to meet the definition of an eligible *Dependent.*

00057 TX

TERMINATION PROVISIONS

When does Your coverage under the Policy end?

Unless coverage is continued under the Portability Benefit, *Your* coverage terminates on the earliest of the following dates:
1. the date on which the *Policy* is terminated; or
2. the date *You* stop making any required contribution toward payment of premiums; or
3. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
4. the earliest of:
    a. the date *You* die; or
    b. the date *You* are no longer a member of a class eligible for this insurance; or
    c. the date *You* request termination of coverage under the *Policy;* or
    d. the first of the month following the date *You* reach age 70; or
    e. the date *You* are no longer *Actively at Work* as a result of a *Disability*, layoff, or leave of absence or sabbatical, or military leave or Reserve National Guard.

Termination will not affect an eligible claim for *Injuries* the *Covered Person* sustained in an *Accident* which occurred while the coverage was in force.

You may continue to be eligible for coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the *Disability* began, if all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, if all premiums are paid when due.
Leave of Absence	Until the end of the month following the month during which the leave of absence began, if all premiums are paid when due, as governed by the *Policyholder's* Human Resource policy on family and medical leaves of absence or in accordance with the FMLA provision below.
Sabbatical	Until the end of the month following the sixth month in which the sabbatical began, if all premiums are paid when due.
Military Leave	Until the end of the twelfth month following the month in which the military leave began, if all premiums are paid when due.
Reserve National Guard	If *You* are a member of an organized United States Reserve Corps or National Guard Unit, coverage will continue while *You* are: 1. In attendance at annual field training, cruise or other active duty training period of less than 60 days (except while attending a service school lasting beyond 60 days, in which case coverage will extend for the duration of the school); or 2. on the way to or from such training; or 3. participating in an authorized periodic inactive duty training, assembly or other inactive duty training authorized by unit orders; or 4. participating as a member of *Your* unit in an authorized parade, exhibition or ceremony.

For the purposes of this provision, ***Disability*** means *You* are unable to perform all of the *Material and Substantial Duties* of *Your Regular Occupation*.
00058

Will coverage be continued if You are eligible for leave under FMLA?

In the event *You* are eligible for and the *Policyholder* approves a leave of absence under the Family and Medical Leave Act of 1993 and its amendments (FMLA), or any applicable state family and medical leave law provided the *Policyholder* continues to pay *Your* required premium, *Your* coverage will continue for a period of up to the later of:
1. the leave period permitted by the federal FMLA; or
2. the leave period permitted by applicable state law.

You are eligible for leave under this Act in order to provide care:
1. After the birth of a *Child*; or
2. After the legal adoption of a *Child*; or
3. After the placement of a foster *Child* in *Your* home; or
4. To a *Spouse*, *Child* or parent due to their serious *Illness*; or
5. For *Your* serious health condition; or
6. For any event later added by amendment to the Act.

During *Your* FMLA period:
1. The *Policyholder* must remit the premium required by the *Policy*; and
2. Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* leave of absence agreement with the *Policyholder*.

00059

When does Dependent coverage end?

Unless insurance is continued under the Portability Benefit provision, *Dependent* coverage will end on the earliest of:
1. the first premium due date *You* are no longer an *Employee* (except in the case of *Disability*, layoff, or leave of absence or sabbatical, or military leave or Reserve National Guard as set forth above); or
2. the date on which the *Policy* is terminated; or
3. the first premium due date *You* stop making any required contribution toward payment of premiums; or
4. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
5. the first premium due date *You*:
   a. are no longer a *Member* of a class eligible for this insurance; or
   b. request termination of coverage under the *Policy*; or
   c. reach age 70; or
   d. are retired or pensioned; or
6. the date a *Dependent Child* or *Spouse* no longer meets the Policy definition of *Dependent;* or
7. the first of the month following 90 days after the date of *Your* death. Premium will not be payable during this period.

Coverage will continue past the age limit for *Dependent Children* who are primarily dependent on *You* for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Written proof of such incapacity must be provided to *Us* on request.

00060

GENERAL PROVISIONS

Entire Contract; Changes

The Entire Contract consists of:
1. The Group Insurance *Policy*;
2. The *Application*;
3. This *Certificate*;
4. The *Enrollment Forms* of the persons insured, including any individual statements; and
5. Any riders; endorsements; or amendments to the *Policy* or the *Certificate*.

Coverage under the *Policy* can be amended by mutual consent of the *Policyholder* and *Us*. No change in the *Policy* is valid unless approved in writing by one of *Our* officers. No agent has the right to change the *Policy* or to waive any of its provisions.

Statements on the Application

All statements made in any signed *Application*, or other written and signed statement, are considered representations and not warranties (absolute guarantees). No representation by:
1. the *Policyholder* in applying for the *Policy* will make it void unless the representation is contained in the signed *Application* or other written and signed statement; or
2. any *Employee* in enrolling for insurance under the *Policy* will be used to reduce or deny a claim unless a copy of the Application for Insurance or other written and signed statement, if applicable, has been signed by the *Employee* and has been given to the *Employee*.

Legal Actions

Unless otherwise provided by federal law, no legal action brought to recover on the *Policy* of any kind may be filed against *Us*:
1. until 60 days after proof of claim has been given; or
2. more than 3 years after proof of the *Accident* must be filed, unless the law in the state where *You* live allows a longer period of time.

Clerical Error

Clerical error or omission by *Us* to the *Policyholder* will not:
1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the *Policy*; or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about *You* that is incorrect, *We* will:
1. Use the facts to decide whether *You* have coverage under the *Policy* and in what amounts; and
2. Make a fair adjustment of the premium.

Incontestability

The validity of the *Policy* shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. No statement *You* made relating to *Your* insurability under the *Policy* will be used to contest the validity of the insurance with respect to which such statement was made after such insurance has been in force for two years during *Your* lifetime, and in no event unless the statement is contained in a written instrument signed by *You* and a copy is given to *You* or to *Your* beneficiary.

Premium Provisions

Premiums are payable in United States dollars on or before their due dates. The *Policyholder* has agreed to deduct from *Your* pay any premiums payable for *Your Contributory* coverage. The *Policyholder* agrees to and is responsible for remitting such premiums for the entire time coverage under the *Policy* is in effect.

Premium charges for increases in insurance amounts becoming effective during a *Policy* month will begin on the next premium due date. Premium charges for insurance terminating during a *Policy* month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have become effective or terminated.

Misstatement of Age

If *You* have misstated *Your* age or the age of a *Dependent*, the true age will be used to determine:
1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that *You* should have been paid if the true age had been known.

Conformity with State Statutes and Regulations

If any provision of the *Policy* conflicts with the statutes and regulations of the state in which the *Policy* was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.

Assignment

Insurance, if any, on *Your Spouse* or *Child* is not assignable. *You* have the right to make an absolute assignment of all rights and interest under the *Policy* to any person permitted by law, subject to all of the following terms and conditions:

1. The assignment must transfer rights and interest of all insurance under the *Policy*. *You* may not make a collateral or partial assignment.
2. *Your* rights and interest under the *Policy* include, but are not limited to the following:
    a. the right to make contributions required to keep the insurance in force;
    b. the right to change the beneficiary; and
    c. the right to convert.
3. The assignment will apply to all insurance under the *Policy* in effect on the date of the assignment or which becomes effective after that date. The assignment will have no effect unless it is made in writing, signed by *You*, and delivered to the *Policyholder* during *Your* lifetime. The assignment will take effect on the date *You* signed the assignment, provided the *Policyholder* receives it before benefits are paid or any other action is taken by *Us*. If *We* have paid benefits or taken any other action before the *Policyholder* receives *Your* designation, the assignment will not go into effect. Neither *We*, nor the *Policyholder* are responsible for the validity, sufficiency or effect of the assignment.
4. All insurance benefits will be paid in accordance with the beneficiary designation on file with the *Policyholder*, and the beneficiary provisions of the *Policy* (not to the assignee unless the assignee is also the beneficiary). Any payment made by *Us* in accordance with the beneficiary designation on file with the *Policyholder* and the beneficiary provisions of the *Policy* will fully discharge *Us* to the extent to the payment.
5. *You* may only change an absolute assignment made by *You* with written consent of the absolute beneficiary(s), and a copy of the written consent must be on file with the *Policyholder*.

You may not make any assignment which is inconsistent with these requirements.

On *Your* death, *Your* beneficiary may make an assignment of benefits to a funeral home provided that *We* receive written notice of the assignment prior to payment of any benefits. Any payment made by *Us* to a beneficiary prior to receiving notice of the assignment will fully discharge *Us* to the extent of the payment.
00061 TX

UNIFORM CLAIM PROVISIONS

Initial Notice of Claim

We must receive written notice of the *Accident* within 30 days of the date of the *Accident*, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to any authorized agent of *Ours*.

Telephonic Claim Notification

In lieu of written *Proof*, *We* may accept telephonic notice and *Proof*. All time limits in the *Policy* applicable to the filing of *Proof* and commencement of Legal Actions shall apply to notice and *Proof* filed by telephone or other means acceptable to *Us*.

Claim Forms

Within 15 days of *Our* being notified in writing of a claim, *We* will supply the claimant with the necessary claim forms. The claim form must be completed and signed by the claimant, the *Policyholder* and the claimant's *Physician*. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written *Proof* only if *We* receive written *Proof*, which describes the occurrence, extent and nature of the *Accident* and *Injuries*.

Time Limit for Filing Your Claim

We must receive written *Proof* within 90 days after the date of the *Accident*. If it is not possible to give *Us* written *Proof* within 90 days, the claim is not affected if the *Proof* is given as soon as possible. However, unless the claimant is legally incapacitated, written *Proof* must be given no later than one year after the time *Proof* is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time *Proof* is due. However, benefits may be paid if it can be shown that:

1. It was not reasonably possible to give written *Proof* during the one year period, and
2. *Proof* was given as soon as was reasonably possible.

We will give *You* written response to *Your* claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, *We* notify *You* in writing that an extension is necessary due to matters beyond *Our* control, identify those matters and gives the date by which *We* expect to render a decision. If the extension is due to *Your* failure to submit information necessary to decide *Your* claim, the time for decision shall be tolled from the date on which *We* send *You* notice of the extension until the date *We* receive *Your* response to *Our* request. This period will be no longer than 45 days after *We* have requested the information. At that time *We* will decide *Your* claim based on the information *We* have at that time.

Physical Examination/Autopsy

On receipt of a claim, *We* may have a *Covered Person* examined, at *Our* expense, at any reasonable time. *We* may have an autopsy performed, at *Our* expense, if it is not prohibited by any applicable local law(s).

Who will receive Your Insurance Benefits?

Insurance benefits are payable to *You* unless such benefits have been assigned. The *Policyholder* may not be named as beneficiary. In the event of *Your* death prior to insurance benefits being paid, benefits will be paid according to the Facility of Payment provision.

Facility of Payment

If no named beneficiary survives *You* or if *You* do not name a beneficiary, *We* will pay the amount of insurance:

1. to *Your Spouse*, if living; if not,
2. in equal shares to *Your* then living natural or legally adopted *Children*, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and/or sisters, if living; if not,
5. to *Your* estate.

00062

Do I have the Right to Appeal a Claim Denial?

If *Your* claim is denied, in whole or in part, *You* will receive a written notice giving the following:
- the reason or reasons for the denial;
- the *Policy* provisions on which the denial is based;
- an explanation of what other material or information, if any, may be needed to process the claim and why it is needed;
- the steps that *You* have to follow to have the claim reviewed;
- a statement that *You* have the right to bring a civil action under section 502(a) of ERISA after *You* appeal *Our* decision and after *You* receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to *You* upon request; and
- if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to *Your* medical circumstances, or (ii) a statement that such explanation will be provided to *You* free of charge upon request.

If the claim has been denied, in whole or in part, *You* can appeal the denial to *Us* for a full and fair review. *You* have at least 180 days to appeal from the claim denial.

You may:
a. request a review upon written application within 180 days of the claim denial;
b. request, free of charge, copies of all documents, records and other information relevant to *Your* claim; and
c. submit written comments, documents, records and other information relating to *Your* claim, without regard to whether such information was submitted or considered in the initial benefit determination.

We will make a decision no more than 45 days after *We* receive *Your* appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, *We* notify *You* in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If *Your* claim is extended due to *Your* failure to submit information necessary to decide *Your* claim on appeal, the time for *Your* decision shall be tolled from the date on which the notification of the extension is sent to *You* until the date *We* receive *Your* response to the request.

The decision on appeal will provide the following:
- the reason or reasons for the decision;
- the Plan provision on which the decision is based;
- a statement that *You* are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to *Your* claim for benefits;
- a statement of the claimant's right to bring an action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision and that a copy will be provided free of charge to *You* upon request;
- if the decision is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to *Your* medical circumstances, or (ii) a statement that such explanation will be provided to *You* free of charge upon request; and
- the following statement: "*You* and *Your* plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact *Your* local U.S. Department of Labor Office and *Your* State insurance regulatory agency."

00063

GENERAL DEFINITIONS

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable which occurs while the *Covered Person's* insurance is in effect.
00064

Actively at Work or ***Active Work*** means that *You* must:
1. work for the *Policyholder* on a full-time active basis; or
2. work at least the minimum number of hours set forth in the Schedule of Benefits: and either:
   a. work at the *Policyholder*'s usual place of business; or
   b. work at a location to which the *Policyholder*'s business requires *You* to travel; and
3. not be a temporary or seasonal *Employee*; and.
4. be paid regular earnings by the *Policyholder*.

00065

Anniversary Date means the annual month and day that corresponds with the *Policy Effective Date*.
00066

Annual Enrollment Period means the annual timeframe defined in the Schedule of Benefits when *Employees* can make benefit changes.
00067

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.
00068

Certificate means this *Accident Insurance Certificate.*
00069

Child(ren) means:
1. *Your* natural or step *Child* or *Child* of *Your Registered Domestic Partner* under the age stated in the Schedule of Benefits; or
2. a *Child* under the age stated in the Schedule of Benefits placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the *Child*. Eligibility will continue unless the *Child* is removed from placement; or
3. an unmarried *Child* of *Your Child* who is within the age limits set forth in the Schedule of Benefits and who is *Your* dependent for federal income tax purposes at the time application for coverage of the *Child* of *Your Child* is made. Coverage for a *Child* of *Your Child* may not be terminated solely because the Child is no longer a *Dependent* for tax purposes; or
4. a *Child* for who *You* are required to insure under a medical support order issued under Chapter 154, Family Code or enforceable by a court of the State of Texas.

00070 TX

Chip Fracture means a *Fracture* in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached. A *Chip Fracture* must be diagnosed by a *Physician* by an x-ray.
00071

Contributory means *You* pay all or a portion of the premium for this insurance coverage.
00072

Covered Person means an *Employee or Eligible Dependent* covered under the *Policy.*
00073

Dependent means:
1. *Your* lawful *Spouse or Registered Domestic Partner*; and/or
2. *Your Child*(ren) who are not in active military service; and are within the age limits set forth in the Schedule of Benefits.

00074

Dislocation means a completely separated joint due to an *Injury*. The *Dislocation* must be diagnosed by a *Physician* within 90 days after the date of the *Injury* and require correction by a *Physician*. It can be corrected by open or closed *Reduction*.
00075

Dismemberment means the loss, with or without reattachment, of one or more of the following body parts as the result of an *Injury* sustained within 90 days of a covered *Accident*.

- Arm: actual severance above the elbow
- Leg: actual severance above the knee
- Hand: actual severance above the wrist
- Foot: actual severance above the ankle
- Finger: actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the hand
- Toe: actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the foot
- Eye: loss of the eye or permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200.

Loss of use does not constitute *Dismemberment* except as described in the loss of vision for the Eye.
00076

Enrollment Form means a form acceptable to *Us* that *You* complete to enroll for coverage under the *Policy*.
00077

Emergency Room means a specified area within a *Hospital* that is designated for the emergency care of *Accidental Injuries*. An *Emergency Room* is staffed and equipped to handle trauma, is supervised and provides treatment by *Physicians* and provides care 24 hours per day, seven days a week.
00078

Employee or Eligible Employee means an *Actively at Work*, full-time *Employee* working in the United States of America as shown in the Schedule of Benefits whose principal employment is with the *Policyholder* and who is reported on the *Policyholder*'s records for Social Security and withholding tax purposes.
00079

Fracture means a break in a bone due to an *Injury* that can be seen by x-ray. The *Fracture* must be diagnosed by a *Physician* within 14 days after the date of the *Injury* and require correction by a *Physician*. It can be corrected by open or closed *Reduction*.
00080

Hospital means either of the following:

1. A licensed facility which
   a. maintains on the premises everything necessary for major surgical treatment; and
   b. provides such treatment on an inpatient basis for compensation under the full-time supervision of licensed *Physicians*; and
   c. provides 24-hour service by registered graduate nurses.
2. A free-standing surgical facility which maintains on the premises everything necessary for major surgical treatment available to the *Hospital* on a prearranged basis.

The term *Hospital* does not include an institution which is primarily a place for rest or convalescence, a place for the aged, a nursing home, a place for the treatment of alcohol or drug abuse or any facility primarily affording custodial, educational, or rehabilitative care.
00081

Hospital Confinement or Confinement means the assignment to a bed as an inpatient in a *Hospital* on the advice of a *Physician* or confinement in an observation unit within a *Hospital* for a period of no less than 20 continuous hours on the advice of a *Physician*.
00082

Illness means sickness, disease, pregnancy or complications of pregnancy.
00083

Intensive Care Unit or ICU means a place which:

- Is a specially designated area of the *Hospital* called an *Intensive Care Unit* that 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; and
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement; and
- Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and
- Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the *Intensive Care Unit* on a 24-hour basis; and
- Has a *Physician* assigned to the *Intensive Care Unit* on a full-time basis.

An *Intensive Care Unit* is not a progressive care unit, an intermediate care unit, a private monitored room, sub-acute *Intensive Care Unit*, an observation unit or any facility not meeting the definition of an *Intensive Care Unit* as defined above.

An *Intensive Care Unit* that meets the definition above includes *Hospital* units with the following names:
- *Intensive Care Unit*;
- Coronary Care Unit;
- Neonatal *Intensive Care Unit*;
- Pulmonary Care Unit;
- Burn Unit; or
- Transplant Unit.

00085

Injury means bodily harm resulting directly from an *Accident* and independently of all other causes.
00086

Insured means an *Employee* or *Dependent* covered under the *Policy*.
00087

Male Pronoun whenever used includes the female.
00088

Material and Substantial Duties means duties that are normally required for the performance of *Your Regular Occupation* which cannot be reasonably omitted or modified.
00089

Off the job coverage means benefits are not payable for an *Injury* sustained as part of a *Covered Person's* occupation or for an *Injury* or treatment covered by a Workers' Compensation or occupational disease law.
00092

Outpatient Ambulatory Surgical Center means a facility mainly engaged in performing outpatient surgery. It must:

- be accredited as an ambulatory surgery facility by either the Joint Commission or the Accreditation Association for Ambulatory Care;
- be approved as an ambulatory surgery facility by Medicare; or
- meet all of the following criteria:
    - maintains all appropriate licensing for a facility that provides ambulatory surgery; and
    - is staffed by *Physicians* and nurses, under the supervision of a *Physician*; and
    - has permanent operating and recover rooms; and
    - is staffed and equipped to provide emergency care; and
    - has written back-up arrangements with a local *Hospital* for emergency care.

00094

Paralysis means complete and total loss of use of two or more limbs (paraplegia-four limbs, quadriplegia-lower limbs, or hemiplegia-one side of the body) as the result of a spinal cord *Injury* for a continuous period of at least 30 days. The *Paralysis* must be confirmed by a *Physician* and be expected to be permanent.
00095

Physical Therapist means a person other than a *Covered Person*, a member of a *Covered Person's* immediate family or a *Covered Person's* business associate who is licensed by the state to practice physical therapy, performs services which are allowed by his license and for which benefits are provided by this *Certificate* and practices according to the Code of Ethics of the American Physical Therapy Association.
00099

Physician means a person other than a *Covered Person*, a member of a *Covered Person's* immediate family or a *Covered Person's* business associate, who is licensed to and actively practicing medicine in the United States, and is licensed to treat *Illness* and *Injury*.
00100

Policy means the contract between the *Policyholder* and *Us* including the *Application*, this *Certificate* and any amendments, riders or endorsements.
00101

Policy Effective Date or ***Effective Date*** means the date stated on the *Schedule of Benefits.*
00102

Policyholder means the person, firm, or institution to whom the *Policy* was issued. *Policyholder* also means any covered subsidiaries or affiliates set forth on the face of the *Policy*. If the *Policyholder* is an association the term *Participating Employer* shall be substituted for *Policyholder*.
00103

Proof means evidence satisfactory to *Us* that the *Covered Person* has sustained an *Injury* or treatment listed in the Schedule of Benefits. *We* reserve the right to determine, at *Our* sole discretion, if *Proof* is acceptable under the terms of the *Policy*.
00104

Prosthetic Device / Prosthesis means an artificial device designed to replace a missing part of the body.
00105

Reduction means an open (surgical) or closed (manipulative) repair of a *Fracture* or *Dislocation*.
00106

Registered Domestic Partner means an adult of the same or opposite gender who has an emotional, physical and financial relationship to *You*, similar to that of a *Spouse*, as evidenced by the following:

1. *You* and *Your Domestic Partner* share 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. *You* and *Your Domestic Partner* share a residence and have done so for at least 12 months;
5. Neither *You* nor *Your Domestic Partner* are married to or legally separated from anyone else;
6. *You* and *Your Domestic Partner* are not related to one another by blood closer than would bar marriage; and

Neither *You* nor *Your Domestic Partner* is a *Domestic Partner* of anyone else.

Where the laws of the governing jurisdiction mandate a definition of *Registered Domestic Partner* other than shown above, that definition will be used in the *Policy*.
00107

Regular Occupation means the occupation that *You* are routinely performing when *Your* insurance terminates due to *Disability*. *We* will look at *Your* occupation as it is normally performed in the national economy, instead of how the work tasks are performed for *Your Policyholder* or at *Your* specific location.
00108

Rehabilitation Unit means an appropriately licensed facility that provides rehabilitation care on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational and vocational services to enable patients disabled by an *Injury* to achieve the highest possible functional ability. Services provided by or under the supervision of an organized staff of *Physicians*.

A *Rehabilitation Unit* is not:

- a nursing home;
- an extended care facility;

- a skilled nursing facility;
- a rest home or home for the aged;
- a hospice care facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

00109

Spouse means lawful *Spouse*. *Spouse* will include *Your Registered Domestic Partner*.
00110

Urgent Care Center means a health care facility that is separate from a *Hospital* or a separate unit of a *Hospital* and whose primary purpose is the offering and provision of immediate, short term medical care, without an appointment, for urgent care.
00111

Voluntary means coverage for which *You* pay 100% of the premium.
00112

We, ***Our*** and ***Us*** means Dearborn Life Insurance Company.
00113

You, ***Your*** and ***Yours*** means the *Employee* to whom this *Certificate* is issued and whose insurance is in force under the terms of the *Policy*.
00114

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). This notice summarizes your protections.

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

Individual annuities: Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

Other policy types: Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

Individual aggregate limit: Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

Parts of some policies might not be protected: For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

Texas Life and Health Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. There may be other exceptions that aren't included in this notice. When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Dearborn Life Insurance Company
To get information or file a complaint with your insurance company or HMO:
Call: Regulatory Inquiry Representative at 1-630-691-0365
Toll-free: 1-877-442-4207
Email: DOIComplaintsTX@bcbstx.com
Mail: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call: 1-800-252-3439
Online: www.tdi.texas.gov
Email:
Mail: MC 111-1A
P.O. Box 149091
Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Dearborn Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: Regulatory Inquiry Representative at 1-630-691-0365
Teléfono gratuito: 1-877-442-4207
Correo electrónico: DOIComplaintsTX@bcbstx.com
Dirección postal: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame: 1-800-252-3439
En línea: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A
P.O. Box 149091
Austin, TX 78714

END OF CERTIFICATE

STATEMENT OF ERISA RIGHTS

As a participant in the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.*, as amended ("ERISA"). ERISA provides that all plan paticipants shall be entitled to:

1. Receive Information about Your Plan and Benefits

   a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

   b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

   c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

   If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

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

4. Assistance with Your Questions

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

ERISA INFORMATION STATEMENT

The benefits described in Your certificate are insured by an Insurance Policy ("Policy") issued by Blue Cross and Blue Shield of Texas (“We” or "Insurer"), pursuant to an "Employee welfare benefit plan" (“the Plan”) as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1002(1) established by Your employer, or where applicable, employee organization (the “Policyholder").

Every employee welfare benefit plan must be established and maintained pursuant to a written instrument that provides for a Plan Administrator. Your Plan Administrator has delegated the authority to administer claims under the Policy to the Insurer. As claims administrator, We will make decisions concerning eligibility and benefit determinations in accordance with the Policy provisions.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is the person or entity responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the Employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy and/or Certificate must also be approved in writing by an officer of the Insurer and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. As stated above, the Plan's benefits are provided to You pursuant to an insurance Policy issued to the Company. The Insurer shall, with respect to the Policy:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a), 29 U.S.C. §1105(a). The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits, except as provided in the Plan.

B. CLAIMS PROCEDURE:

When You or Your Beneficiary are eligible to receive benefits, You or Your Beneficiary, or Your authorized representative (collectively, "You") must follow the claim procedures described in Your Group Insurance Certificate by submitting the proper form in writing to the Insurer at:

Claims Department
Blue Cross and Blue Shield of Texas
701 E. 22nd Street
Lombard, IL. 60148
1-877-442-4207

For the purpose of this Section, the terms "written" and "in writing" include "electronic." Any action required to be "written" or "in writing," may be done electronically, where available. If the Insurer uses electronic notices, it will do so in accordance with 29 CFR 2520.104b-1c(i), (iii) and (iv).

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148