UNITED STATES FIRE INSURANCE COMPANY

Wilmington, Delaware
Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724
1-877-673-9797

GROUP BENEFITS – HOSPITAL FIXED INDEMNTY POLICY

POLICYHOLDER:	Associated Sales Professionals
POLICY NUMBER:	US161123
EFFECTIVE DATE:	June 1, 2014
EXPIRATION DATE:	June 1, 2015

The Policy is issued in the state of Florida.
The Policy is governed by the laws of the state of Florida.

The Policy is a legal contract between the Policyholder and United States Fire Insurance Company (herein referenced as "the Company").

The Company agrees to provide insurance, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in the Policy.

The Company and the Policyholder have agreed to all the terms and conditions of the Policy.

The Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in the Policy.

THIS IS INSURANCE FOR A LIMITED FIXED INDEMNITY POLICY.
IT PAYS BENEFITS REGARDLESS OF ANY OTHER INSURANCE.
THE POLICY IS NOT A MAJOR MEDICAL OR COMPREHENSIVE MEDICAL HEALTHCARE POLICY.
PLEASE READ THE POLICY CAREFULLY.

THE POLICY IS OPTIONALLY RENEWABLE.
Non-Participating Insurance

To make an inquiry, obtain information about your coverage or to resolve a complaint call 1-877-673-9797.

Signed for **United States Fire Insurance Company** By:

Douglas M. Libby
Chairman and CEO

James Kraus
Secretary

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SCHEDULE OF BENEFITS

POLICYHOLDER: Associated Sales Professionals

EFFECTIVE DATE: June 1, 2014

POLICY NUMBER: US161123

PREMIUM DUE DATE: Monthly in advance on the 1st of each month

POLICY PERIOD: June 1, 2014 through June 1, 2015

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class. Also, a person may not be covered as a Dependent and a Covered Person at the same time.

Class 1 All active sales representative associates of the Policyholder.

LIMITED FIXED INDEMNTY BENEFITS

THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON:

BENEFIT WAITING PERIOD: 0 days for Sickness per Covered Person

COVERED BENEFIT FOR EACH COVERED PERSON:

Primary Plan	Daily Benefit Amount
Daily Hospital Confinement Benefit	$200 per day for days 1 - 100 for a Hospital Confinement occurring in a Policy Period Benefit is payable in addition to Daily Intensive Care Unit Maximum Total Days for Combined Hospital Confinement and ICU/CCU Benefit is 30

Daily Intensive Care/Coronary Care Unit	$200 per day for days 1 - 30 for an Intensive Care/Coronary Care Unit Hospital Confinement occurring in a Policy Period Benefit is payable in addition to Daily Hospital Confinement Benefit Maximum Total Days for Combined Hospital Confinement and ICU/CCU Benefit is 30
Daily Emergency Room Visits Benefit for Sickness and Injury	$150 per day up to a maximum of 1 day per Policy Period for Sickness and $300 per day up to a maximum of 2 days per Policy Period for Injury
Daily Inpatient Surgery Benefit	$500 per day to a maximum of 1 day per Policy Period
Daily Inpatient Surgery Anesthesia Benefit	$125 per day to a maximum of 1 day per Policy Period
Daily Outpatient Surgery Benefit	$200 per day to a maximum of 1 day per Policy Period
Daily Outpatient Surgery Anesthesia Benefit	$50 per day to a maximum of 1 day per Policy Period
Daily Physician's Office Visits Benefit	$50 per day up to a maximum of 6 days per Plan Year for Medically Necessary visits and an additional 1 day for Wellness Visits for Covered Persons ages 6+ and an additional 3 days for Wellness Visits for Covered Persons ages 5 and under
Daily Outpatient Diagnostic Laboratory Tests and X-rays Benefit	$50 per day up to a maximum of 3 days per Policy Period for Medically Necessary visits

Plus Plan	Daily Benefit Amount
Daily Hospital Confinement Benefit	$500 per day for days 1 - 100 for a Hospital Confinement occurring in a Policy Period Benefit is payable in addition to Daily Intensive Care Unit Maximum Total Days for Combined Hospital Confinement and ICU/CCU Benefit is 30
Daily Intensive Care/Coronary Care Unit	$500 per day for days 1 - 30 for an Intensive Care/Coronary Care Unit Hospital Confinement occurring in a Policy Period Benefit is payable in addition to Daily Hospital Confinement Benefit Maximum Total Days for Combined Hospital Confinement and ICU/CCU Benefit is 30
Daily Emergency Room Visits Benefit for Sickness and Injury	$150 per day up to a maximum of 1 day per Policy Period for Sickness and $300 per day up to a maximum of 2 days per Policy Period for Injury
Daily Inpatient Surgery Benefit	$2,000 per day to a maximum of 1 day per Policy Period
Daily Inpatient Surgery Anesthesia Benefit	$500 per day to a maximum of 1 day per Policy Period
Daily Outpatient Surgery Benefit	$1,000 per day to a maximum of 1 day per Policy Period
Daily Outpatient Surgery Anesthesia Benefit	$250 per day to a maximum of 1 day per Policy Period
Daily Physician's Office Visits Benefit	$75 per day up to a maximum of 6 days per Plan Year for Medically Necessary visits and an additional 1 day for Wellness Visits for Covered Persons ages 6+ and an additional 3 days for Wellness Visits for Covered Persons ages 5 and under
Daily Outpatient Diagnostic Laboratory Tests and X-rays Benefit	$75 per day up to a maximum of 3 days per Policy Period for Medically Necessary visits

Enhanced Plan	Daily Benefit Amount
Daily Hospital Confinement Benefit	$1,500 per day for days 1 - 3 and $500 per day for days 4 - 100 for a Hospital Confinement occurring in a Policy Period Benefit is payable in addition to Daily Intensive Care Unit Maximum Total Days for Combined Hospital Confinement and ICU/CCU Benefit is 30
Daily Intensive Care/Coronary Care Unit	$500 per day for days 1 - 30 for an Intensive Care/Coronary Care Unit Hospital Confinement occurring in a Policy Period Benefit is payable in addition to Daily Hospital Confinement Benefit Maximum Total Days for Combined Hospital Confinement and ICU/CCU Benefit is 30
Daily Emergency Room Visits Benefit for Sickness and Injury	$150 per day up to a maximum of 1 day per Policy Period for Sickness and $300 per day up to a maximum of 2 days per Policy Period for Injury
Daily Inpatient Surgery Benefit	$2,000 per day to a maximum of 1 day per Policy Period
Daily Inpatient Surgery Anesthesia Benefit	$500 per day to a maximum of 1 day per Policy Period
Daily Outpatient Surgery Benefit	$1,000 per day to a maximum of 1 day per Policy Period
Daily Outpatient Surgery Anesthesia Benefit	$250 per day to a maximum of 1 day per Policy Period
Daily Physician's Office Visits Benefit	$75 per day up to a maximum of 6 days per Plan Year for Medically Necessary visits and an additional 1 day for Wellness Visits for Covered Persons ages 6+ and an additional 3 days for Wellness Visits for Covered Persons ages 5 and under
Daily Outpatient Diagnostic Laboratory Tests and X-rays Benefit	$75 per day up to a maximum of 3 days per Policy Period for Medically Necessary visits

The above Hospital Inpatient and Outpatient Benefits will include treatment for Mental Illness or Nervous Disorders and Substance Abuse, as defined herein, on the same basis as any other Sickness.

DEFINITIONS

Please note certain words used in this document have specific meanings. The male pronoun includes the female whenever used. Additional terms may be defined within the provision to which they apply.

The capitalized terms used herein are defined as follows:

"Active Service" or **"Actively at Work"** means the Insured Person is present at His/Her usual place of employment with the Policyholder, or is at another location as assigned or directed by the Policyholder, and is mentally and physically capable of performing the regular duties of the job for which He or She is employed. On any day that is not an Insured Person's regularly scheduled work day (vacation, personal days, and weekends/holidays) the Insured Person will be considered Actively at Work on such day provided He or She is not absent due to any type of leave and was Actively at Work on His/Her last regularly scheduled work day. An Insured Person who usually performs the regular duties of His/Her job at their home is considered Actively at Work if they meet all the above requirements and could work at the Policyholder's usual place of employment if required to do so.

"Accident" means a sudden, unforeseeable external event which:
(1) Causes Injury to one or more Covered Persons; and
(2) Occurs while coverage is in effect for the Covered Person.

"Certificate Holder" means a person to whom an insurance certificate has been issued evidencing coverage under the Policy.

"Child" means the Insured Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Insured Person has legal guardianship (proof will be required). A Child must reside with the Insured Person in a parent-Child relationship and be eligible to be claimed as an exemption on the Insured Person's federal income tax return. NOTE: In the event the Insured Person shares physical custody of the Child with another parent, the requirement that the Child reside with the Insured Person will be waived.

An adopted Child or a foster Child placed with the Insured Person in compliance with Chapter 63 will be covered from the moment of placement in the residence of the Insured Person. In the case of a newborn Child, coverage begins at the moment of birth if a written agreement to adopt such Child has been entered into by the Insured Person prior to the birth of the Child, whether or not the agreement is enforceable. This definition does not include coverage for an adopted child who is not ultimately placed in the residence of the Insured Person in compliance with Chapter 63.

"Civil Union Partner" means the parties to a civil union who are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded to spouses. Throughout the Policy, a party to a civil union shall be included in any definition or use of the terms such as spouse, family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used.

"Company" means United States Fire Insurance Company. Also hereinafter referred to as We, Us and Our.

"Complications of Pregnancy" means a condition which:
- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis;

(c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.

- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include:

- False labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning sickness;
- Preeclampsia; and
- Similar conditions associated with the management of a difficult pregnancy, but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

"Covered Accident" means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss for which benefits are payable.

"Covered Loss or Covered Losses" means an accidental death, dismemberment or other Injury or Sickness covered under the Policy and indicated on the Schedule of Benefits.

"Covered Person" means an Insured Person and Dependent eligible for coverage as identified in the Enrollment, for whom proper premium payment has been made when due, and who is therefore insured under the Policy.

"Dependent" means an Insured Person's:

1) lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner.
2) Children under age 26.

The age limitations will not apply to an Insured Person's unmarried Child who continues to be both chiefly dependent upon the Insured Person for support and maintenance and incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation. If a claim is denied under the Policy for the stated reason that the child has attained the limiting age for Dependent Children specified in the Policy, the notice of denial must state that the Insured Person has the burden of establishing that the Child continues to meet the criteria specified.

"Domestic Partner" means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Insured Person and shared financial assets/obligations with the Insured Person. Both the Insured Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Insured Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

"Enrollment Period" means the period agreed upon by the Policyholder and Us when an Eligible Person may enroll for coverage or an Insured may change benefit elections under the Policy.

"He", "His" and "Him" includes "she", "her" and "hers."

"Hospital" means an institution licensed, accredited or certified by the State that:

1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
4) Has a staff of one or more licensed Physicians available at all times;
5) Provides organized facilities for diagnosis, treatment and surgery, either
   a) on its premises; or
   b) in facilities available to it, on a pre-arranged basis;
6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

1) the Joint Commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

"Hospital Stay or Hospital Confinement" means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

"Immediate Family Member" means a Covered Person's spouse, Domestic Partner, Civil Union Partner, parent, Child(ren) (includes legally adopted or step Child(ren), brother, sister, grandchild(ren), or in-laws.

"Injury" means bodily Injury caused by the direct result of an Accident occurring after the effective date of a Covered Person's coverage under the Policy, while the Policy is in force as to the person whose Injury is the basis of the claim which results, directly and independently of disease, bodily infirmity and all other causes, in a Covered Loss. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

"Insured Person" means an employee of the Policyholder who is eligible, who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person under the Policy. A Dependent covered under the Policy is not an Insured Person.

"Life Status Change" means an event recognized by the Policyholder and Us that qualifies the Insured Person to make changes in coverage at any time other than an Enrollment Period. The following events are all considered Life Status Changes:

1) marriage;
2) divorce, annulment or legal separation from a Spouse, Domestic Partner or Civil Union Partner;
3) birth or adoption of a child;
4) change in a Dependent child's eligibility;
5) death of a Spouse, Domestic Partner or Civil Union Partner;
6) a change in the benefit plan or employment status of the Insured Person's Spouse, Domestic Partner or Civil Union Partner that affects either person's eligibility for benefits.

"Medical Emergency" means a Sickness or Injury for which the Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- Serious disfigurement of the Covered Person;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Treatment for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions.

"Medically Necessary" or "Medical Necessity" means a treatment, drug, device, service, procedure or supply that is:

1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;
2) Prescribed or ordered by a Physician or furnished by a Hospital;
3) Performed in the least costly setting required by the condition;
4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Covered Person, the Covered Person's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

"Mental Illness or Nervous Disorder" means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

"Nurse" means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

"Optionally Renewable" means renewal is at the option of United States Fire Insurance Company.

"Physician" means a person who is a qualified practitioner of medicine. As such, He or She must be acting within the scope of his/her license under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person's Spouse, Domestic Partner or Civil Union Partner] son, daughter, father, mother, brother or sister or other relative."

"Policy Period" means, initially, the period of time from the Effective Date of the Policy until the first Policy Anniversary Date, and thereafter each subsequent 12 consecutive months provided coverage remains in force.

"Policyholder" means the entity shown as the Policyholder in the Schedule of Benefits.

"Pre-existing Condition" means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received by the Covered Person within the 6 month period ending on their Enrollment Date. Genetic information may not be treated as Pre-existing Condition in the absence of a diagnosis of the condition related to such information.

"Sickness" means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person receives medical treatment while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"Spouse" means lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Partner.

"Substance Abuse" means the use of any drug or substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

"We, Our, Us" means United States Fire Insurance Company underwriting this insurance or its authorized agent.

"You, Your, Yours, He or She" means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

Persons eligible to be insured under the Policy are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits. This includes anyone who may become eligible while the Policy is in force.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

An Insured Person's Dependent(s), as applicable, are eligible on the latest of the date:

1) the Insured Person is eligible, if the Insured Person has Dependents on that date; or

2) the date the person becomes a Dependent.

If the Insured Person is in a Class of Eligible Persons and is also eligible as a Dependent, He or She may be Covered only once under the Policy. In no event will a Dependent be eligible if the Covered Person is not eligible.

EFFECTIVE DATE OF INSURANCE

Policy Effective Date. The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date:
An Eligible Person will become insured under the Policy, provided proper premium payment is made, on the latest of:
(1) The Effective Date of the Policy; or
(2) The day He becomes eligible, subject to any required Eligibility Waiting Period, according to the referenced date shown in the Schedule of Benefits.

Newborn and Adopted Children Coverage: Each newborn or adopted Child who becomes a Dependent Child while the Insured Person's insurance is in effect will be a Covered Person for 31 days from the date of birth or placement as described in the Definition of Child. Application must be made and the required premium paid for coverage to continue after the 31 day notice period. If timely notice is given, We may not charge an additional premium for coverage of the child for the duration of the notice period. If timely notice is not given, We may charge an additional premium from the date of birth or placement. If notice is given within 60 days of the birth or placement of the child, We may not deny coverage for the child due to the failure of the Insured Person to timely notify Us of the birth or placement of the Child.

Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to a Covered Person while insured as a Dependent Child under the Policy. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse, Domestic Partner or Civil Union Partner.

Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child, will be covered on the same basis as an adopted Child.

Deferred Effective Date
If the Insured Person or Dependent if applicable, is not Actively at Work on the date coverage would otherwise be effective, coverage will be effective on the date He or She returns to an Actively at Work status. A Dependent's insurance will not be in effect prior to the date an Insured Person is insured.

TERMINATION DATE OF INSURANCE:

Policy Termination Date
Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:
1) The Policy Expiration Date shown in the Policy; or
2) The premium due date if premiums are not paid when due, subject to any Grace Period.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 45 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

In the event of cancellation, the Company will promptly return the unearned portion of any premium paid. If the Policyholder cancels the Policy, the earned premium will be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the Policyholder resided when the Policy was issued. If the Company cancels the Policy, the earned premium will be computed pro rata.

Insured Person's Termination Date
Insurance for an Insured Person will end on the earliest of:
(1) The date He is no longer in an Eligible Class.
(2) The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    (a) The date the premium is fully earned; or
    (b) The Expiration Date of the Policy.
    This does not include Reserve or National Guard duty for training;
(3) The end of the period for which the last premium contribution is made; or
(4) The date the Policy is terminated; or
(5) The date the Insured Person requests, in writing, that his/her coverage be terminated.

Dependent's Termination Date
A Dependent's coverage under the Policy ends on the earliest of:
1) The date the Policy terminates; or
2) The date the Insured Person's coverage ends; or
3) The date the Dependent is no longer a Dependent; or
4) The last day of the period for which premiums have been paid.

Extension of Benefits
If a Covered Person is Totally Disabled when insurance under the Policy ends, We will provide for the continuation of the same Policy benefits in connection with the treatment of a covered Injury or Sickness incurred while the Policy was in effect. Such benefits will only be extended to the earlier of 90 days from the date the coverage ends; the date the maximum amount of benefits have been paid; or the end of the Total Disability.

For the purposes of this provision, "Totally Disabled" or "Total Disability" means, as a result of a covered Injury or Sickness:
1. For the Insured Person, their inability to perform any work or occupation for which they are reasonably qualified or trained; or
2. For an insured Dependent, their inability to engage in most normal activities of a person of like age and sex in good health.

CONTINUATION OF INSURANCE

If the Insured Person's Active Service ends for any reason, other than termination of employment for gross misconduct, insurance for an Insured Person and his or her covered Dependents will continue, if the required premium is paid, until the earliest of the following dates:
1. the 18-month period following the Insured Person's last day of work; or
2. for a covered Dependent, the date the Dependent is no longer eligible; or

3. the date the Policy terminates.

Any change in benefits that occurs during a period of continuation will apply on the date the Insured returns to Active Service.

PREMIUM PROVISIONS

Premiums:
The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

Grace Period:
A Grace Period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Policyholder pays all the premiums due by the last day of the Grace Period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Policy. Coverage will end if the premium is not paid by the end of the Grace Period.

Changes in Premium Rate
The Company may change the premium rates from time to time with at least 45 days advanced written or authorized electronic notice. Notice will be sent to the Policyholder's most recent address in Our records.

However, the Company reserves the right to change rates at any time if any of the following events occur:
1) A change in the terms of the Policy.
2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
3) A change in any federal or state law or regulation affecting the Policy and Our benefit obligation.
4) A change in the factors bearing on the risk assumed.
5) A misrepresentation in the information relied on in establishing the rate for the Policy.

Reinstatement
The Policy may be reinstated within 30 days of lapse if it is lapsed for nonpayment of premium, if the Policyholder submits written application to the Company, the Company accepts the application and the Policyholder makes payment of all overdue premiums.

If an Insured Person’s insurance ends for nonpayment of premium, insurance may be reinstated for an Insured Person and His or Her Dependents within 30 days.

The following conditions must be met for insurance to be reinstated:
1. the Policy remains in force;
2. the Insured Person and His or Her Dependents are eligible under the Policy;
3. a written request for reinstatement and a new enrollment form are sent to Us; and
4. the required premium is paid.

Any benefits paid during the Policy Period in which the Insured Person’s and His or Her Dependents’ insurance is reinstated will be applied towards the Benefit Amounts for that Policy Period.

Reinstated insurance will be effective on the later of the date the Insured Person returns to Active Service or the date the required premium and new enrollment form are received by Us. We will not pay benefits while insurance is not in force under the Policy.

DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under the Policy.

Daily Hospital Confinement Benefit

We will pay the Daily Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined as an inpatient and all of the following conditions are met:

1. the Hospital stay is Medically Necessary and the direct result, from no other causes, of Injuries or illness sustained in a Covered Accident or Sickness; and
2. Confinement is at the direction and under the care of a Physician; and
3. While the coverage is in effect.

This benefit will be paid in addition to the Daily Intensive Care/Coronary Care Unit Benefit.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit for this benefit is payable; or
4. the date insurance under the Policy ends.

Daily Intensive Care/Coronary Care Unit Benefit

We will pay the Intensive Care Unit (ICU)/Coronary Care Unit (CCU) Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined in the Intensive Care Unit and all of the following conditions are met:

1. the ICU/CCU confinement is Medically Necessary and the direct result, from no other causes, of Injuries or illness sustained in a Covered Accident or Sickness; and
2. ICU/CCU stay is at the direction and under the care of a Physician;
3. While the coverage is in effect.

Benefit payments will end on the first of the following dates:

1. the date the ICU/CCU stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit for this benefit is payable; or
4. the date insurance under the Policy ends.

This benefit will be paid in addition to the Daily Hospital Confinement benefit.

Daily Emergency Room Visits Benefit for Sickness and Injury

We will pay the benefit shown in the Schedule of Benefits for Emergency Room Visits if a Covered Person requires Hospital emergency room treatment for a Medical Emergency as the result of a Covered Accident or Sickness.

“Emergency Room” means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician’s office.

Daily Inpatient Surgery Benefit

We will pay the Daily Inpatient Surgery Benefit shown in the Schedule of Benefits if a Covered Person is ordered by a Physician to undergo Medically Necessary Surgery as the result of a Covered Accident or Sickness.

"Surgery" means the treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including the usual aftercare for such procedure, that is:

1. necessary for treatment of the Covered Person; and
2. performed in a Hospital.

Inpatient Surgery must be performed in the operating room of a Hospital.

Daily Inpatient Surgery Anesthesia Benefit

We will pay the Daily Inpatient Anesthesia Benefit shown in the Schedule of Benefits if a Covered Person is administered anesthesia on an inpatient basis for a Medically Necessary Surgery as the result of a Covered Accident or Sickness.

Daily Outpatient Surgery Benefit

We will pay the Surgery Benefit shown in the Schedule of Benefits if a Covered Person is ordered by a Physician to undergo Medically Necessary Surgery as the result of a Covered Injury or Sickness.

"Surgery" means the treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including the usual aftercare for such procedure that is necessary for treatment of the Covered Person.

Outpatient Surgery must be performed in the outpatient department of a Hospital or an Ambulatory Surgical Center.

“Ambulatory Surgical Center” means a free standing facility providing ambulatory surgical or medical treatment other than a Hospital, clinic or Physician’s office. It must be qualified to provide the treatment under the standards set by the state in which it is located.

This does not include Surgery performed in a surgical suite or Physician’s office.

Daily Outpatient Surgery Anesthesia Benefit

We will pay the Daily Inpatient Anesthesia Benefit shown in the Schedule of Benefits if a Covered Person is administered anesthesia on an outpatient basis for a Medically Necessary Surgery as the result of a Covered Accident or Sickness.

Daily Physician's Office Visits Benefit

We will pay the benefit shown in the Schedule of Benefits for Physician's Office Visits if a Covered Person visits a Physician's office, Hospital clinic, or urgent care center and receives Medically Necessary treatment, care or advice of a Covered Accident or Sickness.

In addition to Medically Necessary treatment We will also cover Wellness Visits for an annual routine examination or well-child care. These services will be covered only to the extent that they are provided by, or under the supervision of, a single Physician during the course of one visit. Covered Wellness Services include:

1. a history and physical examination;
2. X-rays and laboratory tests including, but not limited to, a Pap test, colorectal screening, prostate cancer screening, mammography and bone density screening; and
3. immunizations as provided by department of health regulation.

Daily Outpatient Diagnostic Radiology, X-ray and Imaging Benefits

We will pay the benefit shown in the Schedule of Benefits for Outpatient Diagnostic X-ray, Radiology or Imaging services if the following conditions are met:

1. a Covered Person is not confined in a Hospital; and
2. the diagnostic X-rays are ordered by a Physician and performed by an appropriately licensed technician.

This includes diagnostic testing such as X-Rays, CT scan, PET Scan, Ultrasound and MRI.

This does not include Radiation Therapy.

"Radiology Tests" are the scientific discipline of medical imaging using ionizing radiation, radionuclides, nuclear magnetic resonance, and ultrasound.

Daily Outpatient Laboratory Test Benefit

We will pay the benefit shown in the Schedule of Benefits for Outpatient Laboratory Tests if the following conditions are met:

1. a Covered Person is not confined in a Hospital; and
2. the laboratory tests are ordered by a Physician and performed by an appropriately licensed technician.

"Laboratory tests" are procedures that are intended to detect, identify, or quantify one or more significant substances, evaluate organ functions, or establish the nature of a condition or disease.

EXCLUSIONS

The Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following:

1. Suicide, attempted suicide or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared, however under this Exclusion the term "war" does not include acts of terrorism.
3. while the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps.
4. Active participation in a riot or insurrection.

5. Treatment which arises out of, or in the course of assault or battery, except when these actions are committed upon the Covered Person.
6. Injury or Sickness caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
7. Violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
8. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family Member of the Covered Person.
9. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
10. Travel or activity outside the United States, except for a Medical Emergency.
11. Injury to a Covered Person resulting from that Covered Person's willful violation of the Policyholder's rules or regulations. Willful violation includes, but is not limited to: a) working without protective clothing, helmets, gloves, etc., required by the Policyholder's rules or regulations; or b) participating in any activity that is in violation of the Policyholder's rules or regulations.
12. Experimental or Investigational drugs, services, supplies or procedure that is Experimental or Investigational at the time the procedure is done. For the purposes of this exclusion, "Experimental or Investigational" means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The procedure will also be considered Experimental or Investigational if the Covered Person is required to sign a consent form that indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, that is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental or Investigational. A drug, device or biological product is considered Experimental or Investigational if it does not have FDA approval or approval under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption.
13. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
14. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in the Policy.
15. Treatment for blood or blood plasma.
16. Routine vision care.
17. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license.
18. Rest cures or custodial care.
19. Prescription Drugs unless specifically provided for under the Policy.
20. Elective or cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body.
21. Physiotherapy services.

Pre-existing Conditions Limitation

Pre-existing Conditions will not be covered until the expiration of the first 6 months after the Covered Person's Enrollment Date (applies to Hospital, Surgery and related Anesthesia benefits only).

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of claim must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given at Our administrative office as shown on the cover page or to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:
1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
2) it is further shown that notice was given as soon as possible.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not provided within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to Us in the case of a claim for Covered Loss for which the Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by Us.

In case of claim for any other Covered Loss, proof must be furnished within 90 days after the date of such loss.

If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:
1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and
2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS:

Benefits due under the Policy for a Covered Loss, other than a loss for which the Policy provides installments, will be paid immediately upon receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for a Covered Loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss.

The Company will reimburse all claims or any portion of any claim from the Insured Person or their assignee, for payment under the Policy, within 45 days after the Company receives the claim. If a claim or a portion of a claim is contested by the Company, the Insured Person or their assignee shall be notified, in writing, that the claim is contested or denied, within 45 days after the Company receives the claim. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested from the Insured Person or their assignee, the Company will pay or deny the contested claim or portion of the contested claim within 60

days. The Company will pay or deny any claim no later than 120 days after the Company receives the claim.

Payment will be treated as being made on the date a draft or other valid instrument which is equivalent to payment is placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments will bear simple interest at the rate of 10 percent per year.

PAYMENT OF CLAIMS:

All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Covered Person's death may, at Our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

DESIGNATION OR CHANGE OF BENEFICIARY:

Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

1) Beneficiaries designated in writing by the Covered Person for the Policy on file with the Policyholder, if any, otherwise;
2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
3) In equal shares to the members of the first surviving class of those that follow, if any:
    a) a Covered Person’s lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner;
    b) a Covered Person’s natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
    c) a Covered Person’s parents, whether natural, step or adoptive; or
    d) a Covered person’s Sisters or Brothers, otherwise.
4) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time by giving notice, in writing, to the Policyholder. The beneficiary’s consent is not required for this or any other change in the Policy, unless the designation of the beneficiary is irrevocable. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent’s beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent’s death, the beneficiary is the Covered Person’s estate.

PHYSICAL EXAMINATION AND AUTOPSY:

We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy. Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.

RECOVERY OF OVERPAYMENT:

If benefits are overpaid or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods.

1) A request for lump sum payment of the amount overpaid or paid in error; or
2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Covered Person any benefits We have paid to him for a Covered Loss which is covered under:

(a) Workers' Compensation or similar statutory remedies available under law; or
(b) Any employer's liability insurance.

It will be assumed that the Covered Person is in receipt of such Recovery benefits unless He gives Us proof such benefits have been denied to him.

"Recovery" means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for all losses caused by the Injury or Sickness.

SUBROGATION:

If We have paid benefits to a Covered Person for Injuries received in a Covered Accident, and in Our opinion a third party may be liable, We will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer His rights to Us. We will exercise such rights on His behalf. He further agrees to furnish Us with all relevant information and documents.

LEGAL ACTIONS:

All Policy terms will be interpreted under the laws of the state in which the Policy was issued. No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after the expiration of the applicable statute of limitations from the time written Proof of Loss is required to be furnished.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Policy, the Application of the Policyholder (a copy of which is attached to the Policy), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, We may also make it a part of this contract.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause Us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of His death or incapacity, His beneficiary or representative. After two years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in the Policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

The Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

RECORDS MAINTAINED:

The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person's insurance under the Policy.

We shall be permitted to examine the Policyholder's records relating to coverage under the Policy. Examination may occur at any reasonable time up to the later of:
(1) The two year period after the expiration of the Policyholder's coverage; or
(2) The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:

The Policyholder or its authorized agent must report to Us, by the premium due date:
(1) The names of all persons insured on the Effective Date of the Policy;
(2) The names of all persons who are insured after the Effective Date of the Policy;
(3) The names of those persons whose insurance has terminated; and
(4) Additional information required as agreed to by Us and the Policyholder.

CERTIFICATES OF INSURANCE:

A Certificate of Insurance will be delivered to the Policyholder for delivery to each Covered Person. Each Certificate will contain the group number and list the benefits, conditions and limits of the Policy. It will state to whom the benefits will be paid.

POLICY TERMINATION:

We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. If either party terminates, written notice must be given to the other party at least 45 days prior to such premium due date.

In the event of cancellation, the Company will promptly return the unearned portion of any premium paid. If the Policyholder cancels the Policy, the earned premium will be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the Policyholder resided when the Policy was issued. If the Company cancels the Policy, the earned premium will be computed pro rata.

CONFORMITY WITH STATE STATUTES:

Any provision of the Policy in conflict on its effective date with the laws of the State of Florida is amended to conform to the minimum requirements of such laws.

OTHER COVERAGE WITH US:

At any one time each Covered Person may have only one Certificate issued by Us having coverage similar to that described in the Policy. If we find a Covered Person has more than one such Certificate, coverage will be provided under the plan that has been in force for the longer period of time. If concurrent coverage is identified, We will refund premiums paid for all other Certificates for concurrent periods of coverage and provide 30 days written notice of termination to the Insured for the most recently acquired coverage.

CLERICAL ERROR:

Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ASSIGNMENT:

No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY:

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Policy.

NON-PARTICIPATING:

The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

WAIVER:

Failure of the Company to strictly enforce its rights under the Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

Administrative Notice

Policyholder: Associated Sales Professionals **Policy Number: US161123**

Effective Date: June 1, 2014

This Administrative Notice addresses the application of the Pre-existing Conditions Limitation and the Waiting Period for Sickness for the above-referenced Policy/Certificate. Please reference the waiver language below to determine whether or not the Pre-existing Conditions Limitation will apply to your coverage.

Pre-Existing Conditions Limitation & Waiting Period for Sickness:	Waived for all Covered Persons who enroll during the Initial Enrollment, any Open Enrollment, or within 31 days of becoming eligible for those newly eligible including Life Status Change events

"Life Status Change" means an event recognized by the Policyholder and Us that qualifies the Insured to make a change in coverage at any time other than an Enrollment Period. The following events are all considered Life Status Changes:

i. Marriage;
ii. Divorce, annulment or legal separation;
iii. Birth or adoption of a child;
iv. Change in a Dependent child's eligibility;
v. Death of a spouse;
vi. A change in the benefit plan or employment status of the Insured's spouse that affects either person's eligibility for benefits.

Questions can be referred to the Claims Administrator's customer service line at 888-656-6247.

When used throughout this document "Company", "Our", "We", or "Us" means:

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

Grievance

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
(2) a statement of your rights, including the right to:
- attend the Second Level Review
- present his/her case to the review panel;
- submit supporting materials before and at the review meeting;
- ask questions of any member of the review panel;
- be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
- request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

(1) were not previously involved in any matter giving rise to the Second Level Review;
(2) are not employees of the Company or Utilization Review Organization; and
(3) do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

(1) the name(s), title(s) and qualifying credentials of the members of the review panel;
(2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
(3) the review panel's recommendation to the Company and the rationale behind the recommendation;
(4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) the rationale for the Company's decision if it differs from the review panel's recommendation;
(7) a statement that the decision is the Company's final determination in the matter;
(8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

When used throughout this document “The Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Fairmont Speciality
5 Christopher Way, 3rd Floor
Eatontown, New Jersey 07724

IMPORTANT NOTICE

Insurance policies providing certain health insurance coverage are required to comply with all applicable requirements of the Patient Protection and Affordable Care Act (PPACA). However, there are a number of insurance coverages that are specifically exempt from the requirements of PPACA (See § 2791 of the Public Health Services Act).

Fairmont Specialty and United States Fire Insurance Company, Inc. (USF) maintains that this Limited Medical Indemnity Policy is “fixed indemnity insurance”, and is therefore, exempt from the requirements of PPACA.

Fairmont Specialty and USF continue to monitor state and federal laws and regulations to determine any impact on its products. Should there be any change in the applicable laws and regulations that impact this plan, we reserve the right to change the plan and rates accordingly.

Please understand that this is not intended as legal advice. For legal advice on PPACA, please consult with your own legal counsel or tax advisor directly.