

**Group Accident Indemnity
Insurance Certificate**

University of Richmond

IMPORTANT NOTICES

GROUP ACCIDENT INDEMNITY

If you reside in one of the following states, please read the important notice applicable to you.

Arizona residents:

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

California residents:

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON THE EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

Florida residents:

The benefits of the policy providing your coverage are governed primarily by the laws of a state other than Florida.

Louisiana residents:

THIS CERTIFICATE DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA).

Maryland residents:

This Certificate may omit some of the benefits required for a Certificate issued and delivered in Maryland.

New Mexico residents:

This type of plan is NOT considered “minimum essential coverage” under the Affordable Care Act (ACA) and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty. Please consult your tax advisor.

North Carolina residents:

This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but it is issued under a group master policy located in another state and may be governed by that state's law.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE, WHICH IS AVAILABLE FROM LIFE INSURANCE COMPANY OF NORTH AMERICA.

The Policy is a legal contract between the Policyholder and Us.

BENEFITS MAY BE REDUCED. PLEASE SEE THE SCHEDULE OF BENEFITS

IMPORTANT CANCELLATION INFORMATION – PLEASE READ “POLICY TERMINATION” PROVISION

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

Texas residents:

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.

Life Insurance Company of North America
1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235
A Stock Insurance Company

GROUP ACCIDENT INDEMNITY CERTIFICATE

**THIS CERTIFICATE PROVIDES LIMITED COVERAGE.
PLEASE READ YOUR CERTIFICATE CAREFULLY.**

We, the Life Insurance Company of North America, have issued a Group Policy, AI961270 to Trustee of the Group Insurance Trust for Employers in the Services Industry.

We certify that We insure all eligible persons who are enrolled according to the terms of the Group Policy. Your coverage will begin according to the terms set forth in the *Effective Date Provisions* section.

This Certificate describes the benefits and basic provisions of Your coverage. It is not the insurance contract and does not waive or alter any terms of the Policy. If questions arise, the Policy language will govern. You may examine the Policy at the office of the Subscriber or the Administrator.

This Certificate replaces all prior Certificates issued to You under the Group Policy.



William J. Smith, President

30 DAY RIGHT TO EXAMINE CERTIFICATE

Within 30 days of receipt of this Certificate, You can return it to Us for any reason if not satisfied with the insurance provided under this Certificate. We will return any premium that has been paid and this Certificate will be void as if it had never been issued.

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SCHEDULE OF BENEFITS

The Schedule of Benefits provides a brief outline of the coverage and benefits including the maximum benefit amount, benefit periods, and any limitations applicable to benefits provided in this Policy for each Covered Person, unless otherwise indicated.

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Policy provisions carefully.

Covered Classes:

Class 2	All active, Full-time Employees of the Employer regularly working a minimum of 1,511 hours annually, who are lawfully working and residing in the United States under an appropriate visa or work authorization and their Spouse and Dependent Children who are residing in the United States, except non-United States citizens from OFAC sanctioned countries.
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The following pages contain a Schedule of Benefits for each class of eligible Employees. For an explanation of these benefits, please see the *Description of Benefits* section.

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SCHEDULE OF BENEFITS FOR CLASS 2

Subscriber: University of Richmond

Effective Date of Subscriber: January 01, 2020

Minimum Subscriber Participation Requirements:
None

Eligibility Waiting Period:
No Waiting Period

Waiting Period: 0 days unless otherwise specified

BENEFIT AMOUNTS PAYABLE

All Employee benefits are payable at 100% of the Benefit Amount shown for the Eligible Employee.

All Spouse benefits are payable at 100% of the Benefit Amount shown for the Employee.

All Dependent Child(ren) benefits are payable at 100% of the Benefit Amount shown for the Employee.

ACCIDENT INDEMNITY BENEFITS

EMPLOYEE BENEFITS

PLAN 2

INITIAL CARE AND EMERGENCY CARE BENEFITS

<u>Benefit Type</u>	<u>Benefit Amount</u>
Emergency Care Treatment Benefit Amount	\$200
Physician Office Visit Benefit Amount	\$100
Diagnostic Exam Benefit Amount	\$50
Ground Ambulance Benefit Amount	\$400
Water Ambulance Benefit Amount	\$400
Air Ambulance Benefit Amount	\$1,600

HOSPITALIZATION BENEFITS

Benefit Type

Hospital Admission

Benefit Waiting Period 0 days
Benefit Amount \$1,000

Hospital Stay

Benefit Waiting Period 0 days
Benefit Amount \$200 per day
Maximum Benefit Period Up to 365 days

Intensive Care Unit Stay

Benefit Waiting Period 0 days
Benefit Amount \$400 per day
Maximum Benefit Period Up to 365 days

FRACTURES BENEFIT

Benefit Type

FRACTURES

Must be diagnosed and treated by a physician within 90 days of a Covered Accident

	Non-Surgical/Closed	Surgical/Open
	<u>Benefit Amount</u>	<u>Benefit Amount</u>
Skull Pays for non-depressed or depressed skull fractures but not bones of face	\$4,000	\$8,000
Hip or Thigh	\$4,000	\$8,000
Vertebrae or Pelvis Pays for vertebrae, body of vertebrae, or pelvis fracture Will not pay for Coccyx, leg, or vertebral processes fractures	\$4,000	\$8,000
Upper Arm Pays for arm fractures located between elbow and shoulder Will not pay for Shoulder, Lower Arm, or Elbow fractures	\$1,000	\$2,000
Shoulder or Collarbone Pays for shoulder or collarbone fractures only Will not pay for Upper Arm fractures	\$1,000	\$2,000
Leg Will not pay for Thigh, knee, or ankle fractures	\$1,000	\$2,000
Ankle Will not pay for leg, foot, or heel fractures	\$800	\$1,600
Kneecap Will not pay for leg fractures	\$800	\$1,600
Lower Arm Pays for arm fractures located to the elbow and below the elbow Will not pay for Upper Arm or Bones of Wrist fractures	\$800	\$1,600

Foot Will not pay for toe, ankle, or heel fractures	\$800	\$1,600
Hand or Wrist Will not pay for lower Arm or finger fractures	\$800	\$1,600
Upper Jaw Will not pay for lower jaw, teeth, or bones of face fractures	\$600	\$1,200
Lower Jaw Will not pay for Upper Jaw, Teeth, or Bones of face fractures	\$600	\$1,200
Bones of Face or Nose Will not pay for Upper Jaw, Lower Jaw, or Teeth fractures	\$600	\$1,200
Vertebral Processes	\$600	\$1,200
Rib More than 1 rib fracture pays 2 times the Benefit Amount	\$200	\$400
Coccyx We will not pay for Vertebrae or Pelvis fractures	\$200	\$400
Finger More than 1 finger pays 2 times the Benefit Amount. We will not pay for fractures to Hand or Wrist.	\$100	\$200
Toe More than 1 toe fracture pays 2 times the Benefit Amount shown on schedule. We will not pay for Foot, Heel or Ankle fractures.	\$100	\$200
Sternum	\$100	\$200
Heel We will not pay for Foot, Toe, or Ankle fractures	\$100	\$200
Chip Fracture We will not pay in addition to Closed fracture benefit	25% of Closed fracture benefit	Not Applicable
Multiple Fractures We will not pay multiple fracture benefit in addition to single fracture benefits	200% of the single fracture benefit for multiple fractures to the same bone	Not Applicable

DISLOCATIONS BENEFITS

Benefit Type

DISLOCATIONS:

Must be diagnosed and treated by a doctor within 90 days of a Covered Accident

	Non-Surgical/Closed	Surgical/Open
	<u>Benefit Amount</u>	<u>Benefit Amount</u>
Hip Joint	\$3,000	\$6,000
Knee Joint	\$3,000	\$6,000
Bones of Foot	\$3,000	\$6,000
Ankle	\$1,000	\$2,000
We will not pay for Bones of Foot or Toes		
Wrist	\$800	\$1,600
Elbow	\$600	\$1,200
Shoulder	\$400	\$800
Hand	\$400	\$800
Collarbone	\$400	\$800
Lower Jaw	\$400	\$800
Finger or Toe	\$100	\$200
More than 1 finger or toe pays 2 times the benefit		

FOLLOW UP CARE

Benefit Type

Benefit Amount

Follow up Physician Office Visit

\$75

Benefit is limited to 10 treatments per Accident

Follow up Physical Therapy Visits

\$50

Benefit is limited to 10 treatments per Accident

OPTIONAL BENEFITS

ENHANCED ACCIDENT BENEFITS RIDER

All Employee benefits under this Rider are payable at 100% of the Benefit Amount shown for the Eligible Employee.

All Spouse benefits are payable at 100% of the Benefit Amount shown for the Employee.

All Dependent Child(ren) benefits are payable at 100% of the Benefit Amount shown for the Employee.

EMPLOYEE BENEFITS

PLAN 2

<u>Benefit Type</u>	<u>Benefit Amount</u>
Small Burns	\$300
Large Burns (3 rd degree pays 10x multiple)	\$1,000
Skin-Graft Benefit	50% of the applicable Benefit amount for Small Burns or Large Burns
Small Lacerations	\$100
Large Lacerations	\$600
General Anesthesia Benefit	\$100
Medicine Benefit	\$10
Medical Supply Benefit	\$10
Abdominal or Thoracic Surgery	\$1,250
Tendon, Ligament, Rotator Cuff, or Knee Surgery - Repair	\$400
Tendon, Ligament, Rotator Cuff, or Knee Surgery - Exploratory	\$150
Ruptured Disc Surgery - repair	\$750
Eye Injury Surgery	\$400
Eye Injury - Removal of Foreign Object	\$200
Emergency Dental - Extraction	\$150
Emergency Dental - Broken Tooth	\$75
Concussion	\$150
Coma	\$10,000
Diagnostic Advanced	\$150
Appliance	\$150
Prosthesis	\$1,000
Paralysis - Paraplegia	\$5,000
Paralysis - Quadriplegia	\$10,000
Blood, plasma, platelets	\$200
Transportation	\$400
Family Lodging	\$150 per day

WELLNESS TREATMENT, HEALTH SCREENING TEST AND PREVENTIVE CARE BENEFIT RIDER

All Employee benefits under this Rider are payable at 100% of the Benefit Amount shown for the Eligible Employee.

All Spouse benefits are payable at 100% of the Benefit Amount shown for the Employee.

All Dependent Child(ren) benefits are payable at 100% of the Benefit Amount shown for the Employee.

Benefit Waiting Period

0 days

EMPLOYEE BENEFITS

PLAN 2

Benefit Type

Benefit Amount

Wellness Treatment Benefit

Health Screening Test Benefit

Preventive Care Benefit

Benefit Amount

\$50 per day

Maximum Benefit Period

1 per year.

Continuation Options

Applicable Coverage(s)	Accident Indemnity Benefits and Optional Benefits for Employee, His Spouse and Dependent Child
For Family Medical Leave Maximum Benefit Period	up to 6 months
For Leave of Absence Maximum Benefit Period	up to 12 months
For Sabbatical Leave of Absence Maximum Benefit Period	up to 24 months
For Leave due to Disability Maximum Benefit Period	up to 26 weeks

PREMIUM INFORMATION

INITIAL PREMIUM

Premium:	Refer to your Plan and Rate Confirmation as provided at time of enrollment or application
Contribution(s):	The cost of coverage is paid by the Employee

PREMIUM DUE DATES

The Policy Effective Date and the first day of each succeeding modal period.

Premium rates are subject to change in accordance with the Changes in Premium Rates provision of the *Administrative Provisions* section of this Policy.

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DESCRIPTION OF COVERAGES AND BENEFITS

This Description of Coverages and Benefits Section describes the Accident Coverages and Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits*. Certain words capitalized in the text of these descriptions have special meanings within this Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these coverages and benefits.

INITIAL CARE AND EMERGENCY BENEFITS

EMERGENCY CARE TREATMENT

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires Emergency Room Treatment due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Condition

1. This benefit is payable once per Covered Accident, per Covered Person.
2. Treatment must occur within 30 days of accident for benefit to be payable.

Definition

For purposes of this benefit:

Emergency Room means a trauma center or a 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.

Immediate Family Member means a person who is related to the Insured in any of the following ways: Spouse, and child (includes legally adopted child or stepchild).

Exclusions

Benefits will not be payable for treatment provided by an Immediate Family Member.

Other exclusions that apply to this benefit are in the *Common Exclusions* Section.

PHYSICIAN OFFICE VISIT

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires a Physician Office Visit due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

Must be diagnosed and treated by a Physician within 90 days of the Covered Accident.

Benefit Limitations

1. This benefit is not payable if a Covered Person is eligible to receive a benefit under Emergency Care Treatment.
2. Only 1 benefit will be paid for each Covered Person per Covered Accident.

Exclusions:

This benefit is not payable for routine health examinations or immunizations for Covered Persons Age 60 and older, for visits for Mental or Nervous Disorders, or for visits by a surgeon while confined in a Hospital.

Other exclusions that apply to this benefit are in the *Common Exclusions* Section.

DIAGNOSTIC EXAM BENEFIT

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person requires diagnostic x-ray and laboratory examinations due to a Covered Injury as prescribed by a Physician that results directly and independently of all other causes from a Covered Accident. This benefit will be payable in addition to Emergency Care Treatment and/or Physician Office Visit benefits.

Benefit Conditions

Examination must occur within 90 days of the Covered Accident.

Benefit Limitations

1. This benefit pays for 1 diagnostic examination per Covered Accident.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

AMBULANCE BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, if the Covered Person requires ambulance services due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. The ambulance services provided must be for ground, water, and air transportation from the scene of the Covered Accident to the nearest Hospital that is able to provide appropriate care, or for transportation to the nearest Hospital within 90 days of the Covered Accident or between Hospitals.
2. This benefit is payable once per Covered Accident, per Covered Person.

Benefit Limitations

1. We will pay this benefit in addition to the Emergency Care Treatment benefit.
2. We will only pay one benefit, ground, water, or air ambulance whichever is the greater amount.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

HOSPITAL BENEFITS

HOSPITAL ADMISSION

We will pay the benefit shown in the *Schedule of Benefits*, if the Covered Person requires a Hospital Admission. This benefit will pay in addition to the Emergency Care Treatment benefit, Hospital Stay Benefit or Intensive Care Unit Stay Benefit.

Benefit Conditions

1. admission occurs within 90 days of the Covered Accident; and
2. the Hospital Stay is as an inpatient, as defined by the Policy; and
3. the admission is the first Hospital admission for such Covered Accident; and
4. the benefit is payable on Day 0; and
5. this benefit will be paid only one time per Covered Accident.

Benefit Limitation

This benefit will not be payable if:

1. treatment is given in the emergency room; or
2. treatment is provided on an Outpatient basis; or
3. treatment is for Hospital re-admission for the same Covered Accident.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

HOSPITAL STAY BENEFIT

We will pay the daily Hospital Stay benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the Covered Person requires a Hospital Stay due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident. Benefits are payable for up to 365 days.

Benefit Conditions

The Hospital Stay must meet all of the following:

1. be at the direction and under the care of a Physician;
2. begin within 90 days of the Covered Accident;
3. begin while the Covered Person's insurance is in effect; and
4. The Covered Person must be admitted for at least 23 hours or on an Inpatient basis.

The benefit will be paid for each day of a continuous Hospital Stay. If the Hospital Stay begins during the Benefit Waiting Period, the benefit will be paid for each continuous day that extends after the end of the Benefit Waiting Period, as shown in the *Schedule of Benefits*. If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.

Benefit Limitations

1. This benefit will not be payable for hospital re-admission for same Covered Accident.
2. If a benefit is payable under the Hospital Stay Benefit as well as under the Intensive Care Unit Stay Benefit, only 1 benefit will be paid for the same Covered Accident, which is the greater amount.
3. If the Covered Person leaves the Hospital and then returns within 90 days for the same or a related Covered Accident, We will still count that as one Hospital Stay. However, if the Covered Person is out of the Hospital for at least 90 days and then returns for the same or a related Covered Accident, We will count that as a different Hospital Stay.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

INTENSIVE CARE UNIT STAY BENEFIT

We will pay the benefit shown in the *Schedule of Benefits* subject to the following conditions and exclusions, if the Covered Person is confined in an ICU of a Hospital due to a Covered Accident resulting directly and independently of all other causes from a Covered Accident. Benefits are payable only for up to ISNULL spent in an ICU for each Stay.

Benefit Conditions

The ICU Stay must meet all of the following:

1. be at the direction and under the care of a Physician;
2. begin within 90 days of the Covered Accident;
3. begin while the Covered Person's insurance is in effect.
4. the Covered Person must be admitted for at least 23 hours or on an Inpatient basis.

The benefit will be paid for each day of a continuous ICU Stay. If the ICU Stay begins during the Benefit Waiting Period, the benefit will be paid for each continuous day that extends after the end of the Benefit Waiting Period, as shown in the *Schedule of Benefits*. If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.

Benefit Limitations

1. This benefit will not be payable for Hospital re-admission for same Covered Accident.
2. If a benefit is payable under the Hospital Stay Benefit as well as under the Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, which is the greater amount.
3. If the Covered Person leaves the ICU and then returns within 90 days for the same or a related Covered Accident, we will still count that as one Stay. However, if the Covered Person is out of the ICU for at least 90 days and then returns for the same or a related Covered Accident, we will count that as a different Stay in an ICU.
4. Benefits are limited to 1 ICU stay per month.

Definition For purposes of this benefit:

ICU means an Intensive care or cardiac care unit of a Hospital that:

- a) is for the treatment of patients who are in acute or critical condition;
- b) is furnished with emergency life-saving equipment and supplies that are immediately at hand;
- c) is staffed 24 hours a day by Nurses who are specially trained to work in an intensive care unit; and
- d) is equipped and staffed to monitor each patient's vital signs around-the-clock.

An intensive care or cardiac care unit is not a recovery room. This means that it is not an area used primarily for post-operative or post-anesthesia care.

Stay in an ICU means the period of days that the Covered Person is in an ICU for the same or a related Injury. We will count all days that the Covered Person must spend in an ICU for the same or a related Injury as one Stay. The Covered Person must be admitted to a Hospital for at least 23 hours.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

FRACTURES BENEFIT

We will pay the benefit shown in the *Schedule of Benefits* subject to the following conditions and exclusions, if the Covered Person sustains a Fracture or Chip Fracture due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Condition

Must be diagnosed and treated by a Physician within 90 days of the Covered Accident.

Benefit Limitations

If the Covered Person sustains more than one fracture as a result of such Covered Accident, We will pay one benefit which is the greater amount.

Definition For purposes of this benefit:

Fracture means a bone that is broken as diagnosed by a Physician and corrected by open or closed reduction.

Chip Fracture means a fragment of a bone has been broken off as diagnosed by a Physician.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

DISLOCATIONS BENEFIT

We will pay the benefit shown in the *Schedule of Benefits* subject to the following conditions and exclusions, if the Covered Person sustains a Dislocation or Partial Dislocation due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Condition

Must be diagnosed and treated by a Physician within 90 days of the Covered Accident.

Benefit Limitations

If the Covered Person sustains more than one Dislocation as a result of such Covered Accident, We will pay one benefit, which is the greater amount.

Definition For purposes of this benefit:

Dislocation means a completely separated joint as diagnosed by a Physician that can be corrected by open or closed reduction. A Partial Dislocation is an incomplete separated joint as diagnosed by a Physician.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

FOLLOW-UP CARE

FOLLOW UP PHYSICIAN OFFICE VISIT BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires a Follow-up Physician Office Visit due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident and is examined or treated by a Physician or medical professional in such individual's office. Recommendation from Physician is required and the Covered Person is entitled to payable Initial Care and/or Emergency Care benefits.

Benefit Conditions

Examination or treatment must be provided within 90 days of the Covered Accident. Treatment must be completed within 365 days from the Covered Accident.

Benefit Limitations

1. Only 10 benefits will be paid for each Covered Person per Covered Accident.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

FOLLOW UP PHYSICAL THERAPY BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the Covered Person requires Follow up Physical Therapy due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident. Recommendation from a Physician is required and the Covered Person is entitled to payable Initial Care and/or Emergency Care benefits.

Benefit Conditions

1. Physical therapy must begin within 120 days of the Covered Accident.
2. All treatments must be completed within 365 days of the Covered Accident.

Benefit Limitations

1. Only 10 benefits will be paid for each Covered Person per Covered Accident.

Definitions For purposes of this benefit:

Physical Therapy means manipulation by physical and mechanical means including heat treatment or diathermy, ultrasonic, microtherm, manipulation, adjustment, massage therapy and acupuncture as performed by a licensed Physical Therapist.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

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GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

- Active Service** An Employee will be considered in Active Service with His Employer on any day that is either:
1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a Full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
 2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.
- A Covered Person is not considered in Active Service if he is:
1. Inpatient in a Hospital, receiving hospice or confined in a rehabilitation or convalescence center or custodial care facility;
 2. confined at home under the care of a Physician for Sickness or Injury;
 3. receiving disability benefits from any source due to his or her Sickness or Injury, Totally Disabled; or
 4. unable to perform any of the activities of daily living (i.e. mobility, transferring, feeding, dressing, toileting,) without human supervision or assistance.
- Age** A Covered Person's Age, for purposes of initial premium calculations, is His Age attained on the date coverage becomes effective for him under this Policy. Thereafter, it is His Age attained on the last Policy anniversary.
- Aircraft** A vehicle which:
1. has a valid certificate of airworthiness; and
 2. is being flown by a pilot with a valid license to operate the Aircraft.
- Certificate** *The Certificate*, including the Certificate Schedule, amendments, riders and supplements, if any, is a written statement prepared by us to set forth a summary of:
1. benefits to which the covered person is entitled;
 2. to whom the benefits are payable; and
 3. limitations or requirements that may apply.
- Covered Accident** A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:
1. occurs while the Covered Person is insured under this Policy;
 2. is not contributed to by disease, Sickness, mental or bodily infirmity;
 3. is not otherwise excluded under the terms of this Policy.
- Covered Injury** Any bodily harm that results, directly and independently of all other causes, from a Covered Accident.
- Covered Loss** A loss that is:
1. the result, directly and independently of all other causes, from a Covered Accident; and
 2. one of the Covered Losses specified in the *Schedule of Benefits*.
 3. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits*.
- Covered Person** An eligible person, as defined in the *Schedule of Benefits*, who is enrolled where required, has been accepted by Us, required premium has been paid when due and coverage under this Policy remains in force.

Dependent Child	<p>An Employee's child who meets the following requirements:</p> <ol style="list-style-type: none"> 1. A child from live birth to the end of the year the child attains age 26. 2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. <p>A child, for purposes of this provision, includes an Employee's:</p> <ol style="list-style-type: none"> 1. natural child; 2. adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of the Employee's Spouse provided the child is living with, and is financially dependent upon the Employee; 3. stepchild who resides with the Employee and is financially dependent upon the Employee; 4. child for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.
Emergency Room Treatment	<p>Emergency medical services and care given in a Hospital as an out or inpatient, for a sudden, unexpected onset of a medical condition of such nature that failure to render immediate care could reasonably result in deterioration to the point of placing a Covered Person's life in jeopardy or cause serious impairment to bodily functions.</p>
Employee	<p>For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.</p>
Employer	<p>The Subscriber and any affiliates, subsidiaries or divisions shown in the <i>Schedule of Affiliates</i> and which are covered under this Policy on the date of issue or subsequently agreed to by Us.</p>
Full-time	<p>Full-time means the number of hours set by the Subscriber as a regular work week for Employees in the Employee's eligibility class.</p>
He, His, Him, Himself	<p>Refers to any individual, male or female.</p>
Hospital	<p>An institution that meets all of the following:</p> <ol style="list-style-type: none"> 1. It is licensed as a Hospital pursuant to applicable law; 2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons; 3. It is managed under the supervision of a staff of medical doctors; 4. It provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); 5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis; 6. It charges for its services. <p>The term Hospital does not include a clinic, facility, or unit of a Hospital for:</p> <ol style="list-style-type: none"> 1. rehabilitation, convalescent, custodial, educational or nursing care; 2. the aged, drug addicts or alcoholics.
Hospital Stay	<p>A confinement in a Hospital, ordered by a Physician, over a period of time when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident/Loss. Separate Hospital Stays due to the same Covered Accident/Loss will be treated as one Hospital Stay unless separated by at least 90 days.</p>

Initial Open Enrollment Period	The period in the calendar year when an eligible Employee who was hired on or before the Policy Effective Date may enroll for the first time for Insurance Benefits under this Policy.
Injury	Any accidental loss or bodily harm.
Inpatient	A Covered Person who is confined for at least one full day's Hospital room and board.
Nurse	A licensed graduate registered Nurse (R.N.), a licensed practical Nurse (L.P.N.), or a licensed vocational Nurse (L.V.N.) who is not: <ol style="list-style-type: none"> 1. employed or retained by the Subscriber; 2. living in the Covered Person's household; or 3. a parent, sibling, spouse or child of the Covered Person.
Outpatient	A Covered Person who receives medical tests, treatment, or services from a Hospital, Ambulatory Surgical Center, medical clinic, or Physician's office and is not charged for room and board.
Paralysis	The complete and permanent loss of the use of two or more limbs.
Pathologist	A Physician who is licensed to practice pathological anatomy by the American Board of Pathology. Pathologist also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.
Physical Therapist	A practitioner of physical therapy who is duly licensed in the state where he is practicing and who is practicing within the scope and limitations of that license.
Physician	A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not: <ol style="list-style-type: none"> 1. employed or retained by the Policyholder; 2. living in the Covered Person's household; or 3. a parent, sibling, spouse or child of the Covered Person.
Prior Plan	The plan of insurance, providing similar benefits, sponsored by the Employer in effect immediately prior to this Policy's Effective Date.
Rehabilitation Facility	A legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which: <ol style="list-style-type: none"> 1. is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation Inpatient care; 2. is duly licensed by the appropriate government agency to provide such services; and 3. is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities. <p>A Rehabilitation Facility does not include institutions which provide only minimal care, custodial care, care for the terminally ill, part-time care, or services or facilities for drug abuse or alcoholism.</p>
Related Stays	Successive stays in a Hospital unless: <ol style="list-style-type: none"> 1. any stay after the first is necessitated by causes entirely unrelated to the causes of the earlier stay; or 2. the stays are separated by at least 90 days.

Sickness	A physical or mental illness including pregnancy.
Spouse	The Employee's lawful spouse who is at least Age 18 but not yet Age 100. Except for purposes of determining initial eligibility, the term includes a spouse who is widowed or divorced or legally separated from an Employee.
Subscriber	Any participating organization that subscribes to the Trust to which this Policy is issued.
Totally Disabled or Total Disability	Totally Disabled or Total Disability means either: <ol style="list-style-type: none"> 1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or 2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.
Trust	The Group Insurance Trust for Employers named on the face page of this Policy.
Waiting Period	Waiting Period means the period of time shown in the <i>Schedule of Benefits</i> following the effective date of the Covered Person's insurance. No benefits will be paid for a Covered Loss which occurs during the Waiting Period.
We, Us, Our, Insurance Company	Life Insurance Company of North America.

GAI-00-1200.00

ELIGIBILITY

Employee

An Employee becomes eligible for coverage under this Policy on the date He meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits*. The Eligibility Waiting Period will not apply to an Employee, in Active Service on the Policy Effective Date, who was covered under the Prior Plan and satisfied the Eligibility Waiting Period, if any, of that plan. Credit will be given for any time that was satisfied.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if coverage ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed by the Employer, and within one year becomes a member of an eligible class.

Spouse and Dependent Children

A Spouse and Dependent Children of an eligible Employee become eligible for any dependent coverage provided by this Policy on the later of the date the Employee becomes eligible or the date the Spouse or Dependent Child meets the applicable definition shown in the *General Definitions* section of this Policy. The Employee must be insured under the Policy in order to elect coverage for a Spouse or Dependent Child. An eligible person may be insured only once as of any given date under the Policy as a Covered Person, even though He may be eligible under more than one class of insureds.

ENROLLMENT

An eligible Employee may apply for insurance, subject to the *Deferred Effective Date Provisions* section of this Policy, for Himself or any eligible Spouse or Dependent Child or to increase coverage for any Covered Person under this Policy during the Initial Open Enrollment Period or the Annual Re-enrollment period as agreed to by Us and the Subscriber.

An eligible Employee must be insured for coverage for which He is required to contribute to the cost of insurance in order to apply for coverage for an eligible Spouse or Dependent Child.

During the Initial Open Enrollment Period, an Employee, His eligible Spouse or Dependent Child may become insured under the coverage provided by this Policy.

Any Employee who is not in Active Service on the date His coverage would otherwise become effective under this Policy, may not become covered under this Policy until He returns to Active Service.

If an Employee's eligible dependent is not in Active Service on the date the coverage would otherwise be effective, it will be effective on the date the dependent returns to Active Service.

EFFECTIVE DATE PROVISIONS

Policy Effective Date

The Insurance Company agrees to provide the insurance described in this Policy in consideration of the Subscriber's application and payment of the initial premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page as long as the Minimum Participation Requirements shown in the *Schedule of Benefits* have been satisfied.

Subscriber Effective Date

Insurance becomes effective for each Subscriber in consideration of the Subscriber's application, Subscription Agreement and payment of the initial premium when due. Insurance for the Subscriber becomes effective on the Effective date of Subscriber Participation as long as the Minimum Participation Requirements shown in the *Schedule of Benefits* have been satisfied.

Effective Date for Individuals (*Newly Eligible and Life Status*)

Voluntary Benefit

For all Employee coverage, Evidence of Insurability is not required.

If the Employee applies for coverage and agrees to make required contributions within 31 days after the date He becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the first of the month following the date We or the Employer receive the Employee's completed enrollment form.

For all Spouse coverage, Evidence of Insurability is not required.

If the Spouse is eligible for coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Spouse becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Spouse as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form.

For all Dependent Child coverage, Evidence of Insurability is not required.

If the Dependent Child is eligible for coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Dependent Child becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Dependent Child as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form for Dependent Child coverage.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date the child qualifies as a Dependent Child.

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class, will take effect on the first of the month following such change. Increases will take effect subject to any Active Service requirement.

Benefit Reduction

An Employee may reduce benefits on Himself, Spouse or Dependent Child under this Policy at any time. A benefit reduction, other than requested at an Annual Re-enrollment, will be effective on the date the Insurance Company receives the completed change form. A request for a benefit reduction received during an Annual Re-enrollment will become effective on the Policy anniversary following the enrollment period.

DEFERRED EFFECTIVE DATE PROVISIONS

Active Service

The effective date of coverage will be deferred for any Employee or any eligible Spouse or Dependent Child who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date He returns to Active Service, or the date coverage would otherwise have become effective.

Annual Re-Enrollment and Life Status Change

An Annual Re-Enrollment is a period of time once per year as agreed to by Us and the Subscriber when an Employee can apply for coverage or to increase coverage on Himself, Spouse or Dependent Child under this Policy.

Life Status Change

A Life Status Change is an event that the Employer has determined qualifies an Employee to apply for coverage or to increase coverage on Himself, His Spouse or Dependent Child due to a Life Status Change under this Policy.

Life Status Changes that qualify an Employee to apply or increase coverage for Himself include:

1. marriage;
2. loss of a spouse; whether by death, divorce, annulment or legal separation;
3. birth or adoption of a child, or acquiring a child through marriage;
4. a change in the group benefit plan available to the Employee's Spouse;
5. a change in the Employee's employment status that affects eligibility for group benefits for either the Employee or His Spouse;
6. termination of a Spouse's employment; and
7. as specified in the Employer's Plan which this Policy insures.

Life Status Changes that qualify an Employee to apply or increase coverage for His eligible Spouse and Dependent Child include:

1. marriage;
2. loss of a spouse; whether by death, divorce, annulment or legal separation;
3. birth or adoption of a child, or acquiring a child through marriage;
4. a change in the group benefit plan available to the Spouse;
5. a change in the Spouse's employment status that affects eligibility for group benefits for either the Employee or His Spouse;
6. termination of a Spouse's employment; and
7. as specified in the Employer's Plan which this Policy insures.

Annual Re-Enrollment

An Employee who is eligible to apply, but did not previously enroll, may apply or is insured may apply for an increase for coverage. Changes to coverage for an Employee who applies during the enrollment period and agrees to make required contributions 31 days after enrollment period ends are as follows:

The Employee may apply for an increase in coverage on an insured Spouse or for coverage on a Spouse who is eligible to be insured but was not previously enrolled by the Employee.

The Dependent Child who is eligible to apply, but was not previously enrolled by the Employee, the Employee may apply or is insured the Employee may apply for an increase for coverage.

For all Employee, Spouse and Dependent Child coverage, Evidence of Insurability is not required.

Coverage for which an Employee, Spouse and Dependent Child is eligible will be effective on the effective date of this Policy's anniversary following the enrollment period.

TERMINATION OF INSURANCE

The insurance on a Covered Person will end on the earliest date below:

1. the date this Policy or insurance for a Covered Class is terminated.
2. the date the Subscriber's participation under this Policy ends.
3. the date the Employee is no longer in Active Service.
4. the next premium due date after the date the Employee is no longer in a Covered Class or satisfies eligibility requirements under this Policy.
5. the last day of the last period for which premium is paid.
6. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy, as shown in the *Schedule of Benefits*.
7. with respect to a Spouse or Dependent Child, the date of the death of the covered Employee or the date of divorce from the covered Employee.
8. for a Spouse, the date the Spouse reaches age 100.
9. for a Dependent Child, the end of the year in which the Dependent Child reaches age 26, unless primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap.

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

CONTINUATION OF INSURANCE PROVISIONS

If an Employee is no longer in Active Service, He may be eligible to continue insurance. The following provisions explain the continuation options available under this Policy.

Notwithstanding any other provision of this Policy, if an Employee's Active Service ends due to termination of employment, or any other termination of the employment relationship, insurance will terminate and Continuation of Insurance under this section will not apply.

Continuation for Leave of Absence or Family Medical Leave

If an Employee's Active Service ends due to personal or family medical leave approved timely by the Employer, coverage will continue for up to the Maximum Benefit Period as shown in the *Schedule of Benefits* for family medical leave. Premiums are required for this insurance and are to be remitted directly to the Subscriber.

If an Employee's Active Service ends due to sabbatical leave approved timely by the Employer, coverage will continue for up to the Maximum Benefit Period as shown in the *Schedule of Benefits* for family medical leave. Premiums are required for this coverage and are to be remitted directly to the Subscriber.

If an Employee's Active Service ends due to a leave due to disability approved timely by the Employer, coverage will continue for up to the Maximum Benefit Period as shown in the *Schedule of Benefits* for family medical leave. Premiums are required for this coverage and are to be remitted directly to the Subscriber. (*Applicable to Class 2 only.*)

If an Employee's Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date the Employee ceases work, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. Premiums are required for this insurance and are to be remitted directly to the Subscriber. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

COMMON EXCLUSIONS

Exclusions and Limitations

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits section:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. declared or undeclared war or act of war;
4. a Covered Loss that occurs while on active duty service in the military, naval or air force of any country or international organization. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
5. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
6. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred.
7. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
8. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
 - a. except as a fare-paying passenger on a regularly scheduled commercial airline;
 - b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
 - c. being used for:
 - i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
 - ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
 - d. designed for flight above or beyond the earth's atmosphere;
 - e. an ultra-light or glider;
 - f. being used for the purpose of parachuting or skydiving;
 - g. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
9. travel in any Aircraft owned, leased or controlled by the Subscriber, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Subscriber if the Aircraft may be used as the Subscriber wishes for more than 10 straight days, or more than 15 days in any year;
10. in addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
 - a. employed or retained by the Subscriber;
 - b. providing homeopathic, aroma-therapeutic or herbal therapeutic services;
 - c. living in the Covered Person's household;
 - d. a parent, sibling, spouse or child of the Covered Person;
11. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
12. injuries that occur in the workplace or during the course of any employment for pay, benefit, or profit.

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CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic/telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as is reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Subscriber's name and Policy number and the Your name, address, Policy and Certificate number.

Claim Forms

We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision

Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under the Policy are payable to the Covered Person, if living. If the Covered Person dies while any of these benefits remain unpaid, We may choose to make direct payment to any of the Covered Person's following living relatives: Spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of the Covered Person's estate. Benefits for loss of life will be payable in accordance with the Beneficiary provision and this *Claim Provisions* section.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay \$1,000 to a relative by blood or marriage whom We believe is equitably entitled.

Any payment made by Us in good faith pursuant to this provision will fully discharge Us, and release Us from all liability, to the extent of such payment.

Physical Examination and Autopsy

We, at Our own expense, have the right and opportunity to examine You, Your Spouse and/or Dependent Child when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Beneficiary

The beneficiary is the person or persons You name or change on a form executed by You and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Subscriber. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

You may change the beneficiary at any time by giving written notice to the Subscriber, or the Insurance Company. A beneficiary designation or change will become effective on the date You, Your Spouse or Dependent Child execute it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless You, Your Spouse or Dependent Child have specified otherwise. The share of any beneficiary who does not survive You, Your Spouse or Dependent Child will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Employee dies while benefits are payable to Him, We may make direct payment to the first surviving class of the following classes of persons:

1. Spouse;
2. Child or Children;
3. mother or father;
4. sisters or brothers;
5. Your estate or the estate of Your Spouse and/or Dependent Child of the Covered Person.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when You, Your Spouse or Dependent Child die, We may recover the overpayment from You, Your Spouse's or Dependent Child's estate.

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ADMINISTRATIVE PROVISIONS

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect.

Payment of Premium

Covered Person

You, Your Spouse and/or Dependent Child may be responsible for the payment of premium directly to Us, as determined by the Employer from the Policy Effective Date, or following the expiration of 60 days from the date insurance is continued for You, Your Spouse and/or Dependent Child under the *Continuation of Insurance Provisions* section of the Policy. Premium shall be due monthly, unless You, Your Spouse and/or Dependent Child and the Insurance Company agree on some other period for premium payment. If premium is not paid when due, insurance will end as of the premium due date, except as provided in the Grace Period provision below.

Grace Period

Covered Person

A Grace Period of 31 days will be granted for payment of required premiums under this Policy. Your, Your Spouse's and/or Dependent Child's insurance under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, insurance will end on the last day of the period for which premiums were paid.

Reinstatement of Insurance

If an Employee's Active Service ended due to an Employer-approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, an Employee's insurance may be reinstated at the conclusion of the FMLA leave.

If an Employee's Active Service ends due to the Employer-approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only:

1. if the reinstatement occurs within 12 weeks from the date insurance ends; or
2. when returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

Reinstated insurance will be effective on the date the Employee returns to Active Service. If the Employee did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to an approved unpaid leave of absence, credit will be given for any time that was satisfied.

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GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Subscriber Participation Under This Policy

An organization may elect to participate under this Policy by submitting a signed Subscriber participation agreement to the Policyholder. No participation by an organization is in effect until approved by Us.

Misstatement of Fact

If the Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Certificates

Where required by law, We will provide a Certificate for delivery to the Covered Person. Each Certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

30 Day Right To Examine Certificate

If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Multiple Certificates

The Covered Person may have in force only one Certificate at a time under this Policy. If at any time the Covered Person has been issued more than one Certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one Certificate was issued.

A Covered Person is not eligible for insurance under more than one Certificate providing similar benefits for insurance under group policies issued by Us. If premium is being paid for more than one such Certificate, insurance will be in effect under the Certificate with the earliest effective date and premiums paid for Certificates which are not in effect will be refunded.

Assignment

The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Loss. Any other attempt to assign will be void.

Incontestability

This Policy or Participation Under This Policy

All statements made by the Subscriber to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Subscriber.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used 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 the claimant.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Policy Termination

We may terminate insurance on or after the first anniversary of the Policy Effective Date. The Subscriber may terminate insurance on any Premium Due Date. Written notice by certified mail must be given at least 31 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while insurance was in effect.

Agency

The Employer is acting as Your agent for transactions relating to insurance under the Policy. The actions of the Employer shall not be considered the actions of the Insurance Company, and the Insurance Company is not liable for any of their acts or omissions.

Clerical Error

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Policy Changes

We may agree with the Subscriber to modify a plan of insurance without the Covered Person's consent.

Workers' Compensation Insurance

This Policy is not in place of and does not affect any requirements for insurance under any Workers' Compensation law.

Examination of the Policy

This Policy will be available for inspection at the Subscriber's office during regular business hours.

Examination of Records

We will be permitted to examine all of the Subscriber's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force. Examination may also occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all claims under this Policy.

Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

GAI-00-CE1800.00

ENHANCED BENEFITS RIDER

This Rider is attached to and made a part of your group insurance Policy. It is subject to the terms, conditions, limitations and exclusions contained in the policy as well as those set forth in this Rider.

Rider Effective Date: January 01, 2020

BENEFITS

This Rider provides limited Enhanced Accident Benefits. We will pay the benefit shown in the *Schedule of Benefits*, if any Covered Person incurs a covered loss for which a benefit is payable under this Rider.

Non-Duplication of Benefits

If the Benefits under this Rider would duplicate Benefits payable under the Policy as a result of a Covered Accident, then such Benefits will only be payable under the Policy and not under this Rider.

Small Burns Covering 20% or Less Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person sustains one or more 2nd or 3rd degree burns that covers 20% or less body surface provided the burn is due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

Treatment must be received for the burns within 90 days of the Covered Accident and provided by a Physician.

Benefit Limitations

1. If We pay a 3rd degree burn benefit, We will not pay a 2nd degree burn benefit from the same Covered Accident for the same burned area of the body.
2. This benefit is payable only once per covered person, per accident.
3. This benefit is not payable for burns directly or indirectly caused by or resulting from, sunburn.
4. This benefit will not be payable if a Large Burn Benefit is payable from the same Covered Accident.

Large Burns Covering More Than 20% Benefit (3rd degree pays 10x multiples)

We will pay the benefit shown in the *Schedule of Benefits* if a Covered Person sustains one or more 2nd or 3rd degree burns that covers more than 20% of body surface provided the burn is due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

Treatment must be received for the burns within 90 days of the Covered Accident and provided by a Physician.

Benefit Limitations

1. If We pay a 3rd degree burn benefit, We will not pay a 2nd degree burn benefit from the same Covered Accident for the same burned area of the body.
2. This benefit is payable only once per Covered Person, per Covered Accident.
3. This benefit is not payable for burns directly or indirectly caused by or resulting from, sunburn.

Skin Graft Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires a skin graft as a result of a burn due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. A Small Burns or Large Burns benefit must be paid before We pay this benefit.
2. The skin graft must be performed within 90 days after the Covered Accident.

Benefit Limitations

This benefit is payable only once per Covered Person per Covered Accident.

Small Lacerations Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person is injured and sustains one or more lacerations less than or equal to 6 inches long and requires 2 or more sutures due to a Covered Injury requiring treatment resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

Treatment must be received for the laceration(s) within 90 days from the date of the Covered Accident and provided by a Physician.

Benefit Limitations.

1. For multiple lacerations we will pay a maximum of 2 times the benefit shown in the *Schedule of Benefits*.
2. This benefit is payable only once per Covered Person per Covered Accident.

Large Lacerations Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person is injured and sustains one or more lacerations more than 6 inches long and requires 2 or more sutures due to a Covered Injury requiring treatment resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

Treatment must be received for the laceration(s) within 90 days from the date of the Covered Accident and provided by a Physician.

Benefit Limitations.

1. For multiple lacerations we will pay a maximum of 2 times the benefit.
2. This benefit is payable only once per covered person per Covered Accident.

General Anesthesia Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires Anesthesia for surgery due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. General anesthesia must be administered by a Nurse anesthetist or Physician.
2. The surgery must be performed by a Physician within 90 days from the date of the Covered Accident.

Benefit Limitations.

This benefit is only payable 1 time per covered Accident.

Medicine Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person purchases over-the-counter medications due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

Medicine must be purchased within 90 days from the date of the Covered Accident.

Benefit Limitations.

This benefit is only payable 1 time per Covered Accident.

Medical Supply Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person purchases over-the-counter medical supplies due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

Medical supplies must be purchased within 90 days from the date of the Covered Accident.

Benefit Limitations

1. We will not pay for Durable Medical Equipment.
2. This benefit is only payable 1 time per Covered Accident.

Abdominal or Thoracic Surgery Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires abdominal or thoracic surgery due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

The surgery must be performed by a Physician within 120 days from the date of the Covered Accident.

Benefit Limitations

1. This benefit is only payable 1 time per covered accident.
2. If We pay this benefit, We will not pay for any other surgical benefit.

Tendon, Ligament, Rotator Cuff, or Knee Cartilage Surgery – Repair Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires surgical repair to a tendon, ligament, rotator cuff or knee cartilage due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. The injured area must be torn, ruptured, or severed and the surgical procedure must be performed by a Physician.
2. Surgical repair must occur within 120 days from the date of the Covered Accident.

Benefit Limitations

1. This benefit is only payable 1 time per Covered Accident.
2. If exploratory surgery is performed with no repair, we will not pay this benefit.

Tendon, Ligament, Rotator Cuff, or Knee Cartilage Surgery - Exploratory Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires exploratory surgery to a tendon, ligament, rotator cuff or knee cartilage due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident. We will pay this benefit in addition to the Tendon, Ligament, Rotator Cuff, or Knee Cartilage Surgery – Repair Benefit.

Benefit Conditions

1. This surgery must be performed by a Physician.
2. This surgery must occur within 90 days from the date of the Covered Accident.

Benefit Limitations

1. This benefit is only payable 1 time per Covered Accident.

Ruptured Disc Surgery – Repair Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires surgical repair to a ruptured disc in the spine due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. This surgery must be performed by a Physician.
2. This surgery must occur within 90 days from the date of the Covered Accident.

Benefit Limitations

This benefit is only payable 1 time per Covered Accident.

Eye Injury Surgery Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires surgical repair to one eye or both eyes due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. This surgery must be performed by a Physician.
2. This surgery must occur within 90 days from the date of the Covered Accident.

Benefit Limitations

This benefit is only payable 1 time per Covered Accident.

Eye Injury - Removal of Foreign Object Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires non-surgical removal of a foreign object to one eye or both eyes due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. This non-surgical removal must be performed by a Physician.
2. This non-surgical removal must occur within 90 days from the date of the Covered Accident.

Benefit Limitations

1. This benefit is only payable 1 time per Covered Accident.
2. If the Eye Injury Surgery Benefit is paid this benefit will not be paid for or during the same procedure.

Emergency Dental – Extraction Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires an extraction of one or more teeth due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. The extraction must be performed by a licensed dentist.
2. The extraction must occur within 90 days from the date of the Covered Accident.

Benefit Limitations

For more than one tooth, We will pay 2 times the benefit shown in the *Schedule of Benefits*.

Emergency Dental - Broken Tooth Benefit

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person requires a crown for one or more teeth due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. This procedure must be performed by a licensed dentist.
2. The procedure crown must occur within 90 days from the date of the Covered Accident.

Benefit Limitations

1. If the Dental Extraction benefit is paid we will not pay this benefit for the same tooth, for and during the same procedure.
2. If more than one tooth requires a crown We will pay 2 times the benefit shown in the *Schedule of Benefits*.

Concussion Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires treatment for a concussion due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

The Concussion must be diagnosed by a Physician within 90 days from the date of the Covered Accident.

Benefit Limitations

1. This benefit is payable 1 time per Covered Accident.

Coma Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person is in a Coma due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. We will pay this benefit if a Covered Person is in a state of unconsciousness lasting 7 days with no response to external stimuli and requiring artificial respiratory or life support assistance.
2. Coma must be diagnosed by a Physician and is only payable 1 time per Covered Accident.

Benefit Limitations

We will not pay this benefit if a Coma is medically induced.

Diagnostic Advanced Exam Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires a Diagnostic Advanced Examination due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Diagnostic Advanced Exams are: CT or CAT Scans, MRI, PET, SPECT, or other similar tests. They do not include x-rays or laboratory studies such as blood chemistries, urinalysis, or other similar microscopic study of human blood, fluids, or bodily tissues.

Benefit Conditions

The examination must occur within 90 days of the Covered Accident.

Benefit Limitations

This benefit is only payable 1 time per covered accident.

Appliance Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires a medical appliance for purposes of mobility due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. The medical appliance must be prescribed by a Physician and must meet the definition of Durable Medical Equipment.
2. The appliance must be prescribed within 90 days from the date of the Covered Accident.

Benefit Limitations

1. We will not pay this benefit for prescribed or non-prescribed hearing aids, dentures, eye glasses, cosmetic devices such as wigs, or artificial joint replacements.
2. If more than 1 appliance is required we will pay 2 times the benefit shown in the *Schedule of Benefits*.
3. This benefit is payable 1 time per Covered Accident.

Prosthesis Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires a prosthetic arm, leg, hand, foot, or eye due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. The Prosthesis must be prescribed by a Physician.
2. Prosthesis must be received within 90 days from the date of the Covered Accident.

Benefit Limitations

1. We will not pay for hearing aids, dentures, eye glasses, cosmetic devices such as wigs, or artificial joint replacements.
2. If more than one prosthesis is required We will pay 2 times the benefit shown in the *Schedule of Benefits*.
3. This benefit is payable 1 time per Covered Accident.

Paralysis – Paraplegia or Hemiplegia Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person suffers a spinal cord injury resulting in complete paralysis of 2 or 3 limbs due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. Paralysis must be diagnosed within 90 days from the date of the Covered Accident, and
2. must last for 30 or more days.

Benefit Limitations

We will not pay this benefit if the Paralysis – Quadriplegia Benefit is payable for the same Covered Injury.

Paralysis – Quadriplegia Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person suffers spinal cord injury resulting in complete paralysis of 4 limbs due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. Paralysis must be diagnosed within 90 days from the date of the Covered Accident, and
2. last for 30 or more days.

Benefit Limitations

If more than one Paralysis benefit is payable, We will pay only the largest available benefit.

Blood, Plasma, Platelets Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires a blood plasma or platelets transfusion due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

Transfusion must occur within 90 days of covered accident.

Benefit Limitations

This benefit is only payable 1 time per Covered Accident.

Transportation Benefit

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires treatment that is not available locally due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. Treatment must be prescribed by a Physician.
2. Treatment must be received more than 100 miles one-way from the Covered Person's principal residence.
3. Treatment requires a Hospital Stay for a Covered Person.
4. The Hospital Stay must occur within 90 days from the date of the Covered Accident.
5. Treatment must occur within 90 days from the date of the Covered Accident.

Benefit Limitations

1. This benefit is payable 1 time per Covered Accident.
2. If a Ground, Water or Air Ambulance benefit is payable for a Covered Accident, then no Transportation benefit will be payable for the same Covered Accident or Covered Loss.

Family Lodging Benefit

We will pay the benefit shown in the *Schedule of Benefits*, for the temporary lodging of an immediate family member or caregiver if a Covered Person requires treatment that is not available locally and is due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

Benefit Conditions

1. Treatment must be prescribed by a Physician.
2. Treatment must occur more than 100 miles one-way from the Covered Person's residence.
3. Treatment requires a Hospital Stay for a Covered Person.
4. The Hospital Stay must occur within 90 days from the date of the Covered Accident.
5. Treatment must occur within 90 days from the date of the Covered Accident.

Benefit Limitations

1. This benefit is payable 1 time per Covered Accident.
2. The Benefit is payable for 1 immediate family member or caregiver for up to 30 days.

Definition For purposes of this Rider:

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

Quadriplegia means total Paralysis of both upper and both lower limbs.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Prosthetic Device means an artificial device which is prescribed by a Physician.

Durable Medical Equipment means items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* section.

Renewability/Termination of Coverage

This Rider is renewable. However, this Rider shall automatically terminate on the earliest of the following dates:

1. the date the Covered Person's coverage ends for any reason under the Policy to which this Rider is attached;
2. the end of the period for which premium is paid for this Rider, subject to the Policy's Grace Period provision;
3. the end of the period for which premium is paid for coverage under the Policy, to which this Rider is attached, subject to the Policy's Grace Period provision.

Reinstatement

If the Employee applies for reinstatement of insurance under the Employee's Certificate, the Employee may apply to reinstate this Rider at that time.

This rider terminates at the same time as the policy to which it is attached unless terminated at an earlier date. Except for the above, the rider does not change the policy in any way.

LIFE INSURANCE COMPANY OF NORTH AMERICA



William J. Smith, President

EAB-00-2213.00

WELLNESS TREATMENT, HEALTH SCREENING TEST AND PREVENTIVE CARE BENEFIT RIDER

This Rider is attached to and made a part of your group insurance Policy. It is subject to the terms, conditions, limitations and exclusions contained in the policy as well as those set forth in this Rider. These benefits are not subject to a Pre-Existing Condition Limitation.

Rider Effective Date: January 01, 2020

DESCRIPTION OF COVERAGES AND BENEFITS

The following provisions explain the benefits available under this Rider. Please see the *Schedule of Benefits* for the applicability of these benefits on a class level.

This Rider provides limited Wellness Treatment, Health Screening Test and Preventive Care Benefits. We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person undergoes or receives Wellness Treatment, Health Screening Test and Preventive Care examination, immunization, or testing as set forth below under direction of a Physician while coverage under this rider is in force. Benefits are subject to any applicable Waiting Period, Benefit Period, and Elimination Period.

We will pay the per day benefit shown in the *Schedule of Benefits*, if a Covered Person undergoes or receives Wellness, Health Screening and Preventive Care examination, immunization, or testing as set forth below, under direction of a Physician while coverage under this Rider is in force. Benefits are subject to any applicable Benefit Waiting Period, Maximum Benefit Period, and Elimination Period.

Non-Duplication of Benefits

If the Benefits under this Rider would duplicate Benefits payable under the Policy as a result of a Covered Accident, then such Benefits will only be payable under the Policy and not under this Rider.

Benefit Waiting Period

The Benefit Waiting Period as shown in the *Schedule of Benefits* for this Rider applies.

Maximum Benefit Period

The Maximum Benefit Period is the period commencing on the first date that benefits are payable and continuing for the maximum period shown in the *Schedule of Benefits*.

WELLNESS TREATMENT

- Well Child Care - Visits, Labs and Immunizations;
- Osteoporosis screenings;
- Routine gynecological exams;
- Routine prostate exams;
- General health exams;
- Colorectal cancer screening;
- Lead poisoning screening;
- Cancer screenings; and
- Adult immunizations

HEALTH SCREENING TEST

- Mammography
- Pap Smear for women over Age 18
- Flexible Sigmoidoscopy
- Hemocult Stool Specimen
- Colonoscopy
- Prostate Specific Antigen (for prostate cancer)
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine levels of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography

PREVENTIVE CARE

Patient Protection and Affordable Care Act (PPACA) required preventive health services as recommended by the following expert medical and scientific bodies:

1. the United States Preventive Services Task Force (USPSTF);
2. the Advisory Committee on Immunization Practices (ACIP);
3. the Health Resources and Services Administration (HRSA's) Bright Futures Project; and
4. FRSA and the Institute of Medicine (IOM) committee on women's clinical preventive services.

Detailed information is available at healthcare.gov/what-are-my-preventative-care-benefits

Exclusions

The exclusions that apply to these benefits are in the *Common Exclusions* section of the Policy.

Renewability/Termination of Coverage

This Rider is renewable. However, this Rider shall automatically terminate on the earliest of the following dates:

1. the date the Covered Person's coverage ends for any reason under the Policy to which this Rider is attached;
2. the end of the period for which premium is paid for this Rider, subject to the Policy's Grace Period provision; or
3. the end of the period for which premium is paid for coverage under the Policy, to which this Rider is attached, subject to the Policy's Grace Period provision.

Portability Provision

Coverage under this Rider is portable. Coverage may only be ported if the Covered Person elects to port coverage under the Policy.

Reinstatement

If the Employee applies for reinstatement of insurance under the Employee's Certificate, the Employee may apply to reinstate this Rider at that time.

LIFE INSURANCE COMPANY OF NORTH AMERICAA handwritten signature in black ink, appearing to read "William J. Smith". The signature is written in a cursive style with a large, stylized initial 'W'.

William J. Smith, President

WPB-AI-2214-1.00

MODIFYING PROVISIONS AMENDMENT

Subscriber: University of Richmond

Policy No.: AI961270

Amendment Effective Date: January 01, 2020

This Amendment is attached to and made part of this Policy. Its provisions are intended to conform the Policy/Certificate to the laws of the state in which the insured resides.

The Policy/Certificate is amended as follows:

Arkansas residents:

- 1) Under the *General Definitions* section, the definition of Covered Accident does not include reference to an “external” event.
- 2) Under the *General Definitions* section, the definition of Dependent Child is replaced with the following:

Dependent Child

An Employee’s child who meets the following requirements:

1. A child from live birth to 26 years old;
2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. Premium will continue at the child rate.

A child, for purposes of this provision, includes an Employee’s:

1. natural child;
2. In the case of minor children under an Employee’s charge, care and control for whom the Employee has filed a petition to adopt, coverage will be effective:
 - a. From the date of birth if the petition for adoption is filed and a request for coverage is made within 60 days of the date of birth; or
 - b. On the date of the filing of the petition for adoption if a request for coverage is made within 60 days of the date of filing.

Coverage shall terminate upon the dismissal of a petition for adoption.

3. An unmarried dependent child who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of age 26 years and who is chiefly dependent on the Employee for support and maintenance. Coverage shall continue so long as the coverage of the Employee remains in force and so long as the dependent remains in such condition. At Our request and expense, proof of the incapacity or dependency must be furnished to Us by the Employee, except in no event shall this requirement preclude eligible dependents, regardless of age. If the incapacity or dependency is thereafter removed or terminated, the Employee shall so notify Us.
4. child for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.

Georgia residents:

- 1) Under the *Claim Provisions* section, the Claim Forms provision is replaced with the following:

Claim Forms

We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 10 working days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Louisiana residents:

- 1) The definition of Dependent Child is replaced with the following:

Dependent Child An Employee's natural child, stepchild, foster child, legally adopted child, child of adopting parents pending finalization of adoption procedures, and child for whom coverage has been court-ordered, as follows:

1. unmarried child from live birth under 26 years of age;
2. unmarried grandchild under 26 years of age who is in the Employee's legal custody and residing in the Employee's home;
3. the otherwise applicable limiting age shown above shall not apply to the Employee's unmarried child or grandchild who is incapable of self-support due to a mental or physical incapacity.

Any unmarried child who is placed in the Employee's home pursuant to an adoption placement agreement executed with a licensed adoption agency shall be considered a Dependent Child of the Employee from the date of placement in the Employee's home.

Any unmarried child who is placed in the Employee's home following execution of an act of voluntary surrender in favor of the Employee or the Employee's legal representative shall be considered a Dependent Child of the Employee effective on the date on which the act of voluntary surrender becomes irrevocable.

- 2) Under the *Continuation of Insurance Provisions* section, the Continuation for Military Service provision is replaced with the following:

Continuation for Military Service

If an Employee's Active Service ends due to entry into the armed forces, insurance will continue, if the required premium is paid, until the day the Employee fails to return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994.

All of the following will apply when insurance is continued under this provision:

1. any change in benefits that occurs during the period of continuation will apply on the effective date of the change;
2. any Active Service requirement will be waived;
3. the Employee will be given credit for the time He was covered under this Policy prior to the leave.

If an Employee does not continue insurance during such leave and returns to work:

1. the Employee and His enrolled Spouse and Dependent Children will be covered on the date the Employee returns to work from the leave. The Employee must return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994;
2. any portion of an eligibility waiting period that has not been completed will not be credited during the Employee's leave.

A Spouse or Dependent Child of an Employee, who is covered under the Policy and subsequently called to service in the armed forces, will continue to be considered a Spouse or Dependent Child under the provisions of the Policy, without any lapse of coverage, provided that all required contributions are paid in accordance with Policy provisions.

- 3) Under the *Claim Provisions* section, the Time of Payment of Claims provision is replaced with the following:

Time of Payment of Claims

All claims arising under the terms of the Policy shall be paid not more than 30 days from the date upon which written or authorized electronic notice and proof of claim, in the form required by the terms of the Policy, are furnished to Us unless reasonable grounds, such as would put a reasonable and prudent businessman on His guard, exist. Failure to comply with this provision shall subject Us to a penalty payable to the Covered Person of double the amount of the benefits due under the terms of the Policy during the period of delay, together with attorney's fees to be determined by the court.

- 4) Under the *Administrative Provision* section, the Changes in Premium Rates provisions is replaced with the following:

Changes in Premium Rates

The premium rates may be changed by the Insurance Company from time to time with at least 31 days advance written notice. However, the Insurance Company shall provide at least 45 days advance written notice, for an increase in premium rates that equals or exceeds 20%. No change in rates will be made until 24 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed, if any of the following events take place:

1. The Policy terms change.
2. A division, subsidiary, eligible company, or class is added or deleted.
3. There is a change of more than 10% in the number of eligible Employees.
4. Federal or state laws or regulations affecting benefit obligations change.
5. Other changes occur in the nature of the risk that would affect the Insurance Company's original risk assessment.
6. The Insurance Company determines the Employer fails to furnish necessary information.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

- 5) Under the *General Provisions* section, the first paragraph of the Policy Termination provision is replaced with the following:

We may terminate insurance on or after the first anniversary of the Policy Effective Date. The Subscriber or We may terminate insurance on any Premium Due Date. Written notice with the reason for such termination, by certified mail, must be given at least 60 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.

Massachusetts residents:

Under the *Continuation of Insurance Provisions* section, the following provision is added:

Additional Continuation of Insurance Provisions

If an Employee leaves the group due to termination of employment resulting from a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:

1. 90 days from the date of the Plant Closing or Partial Closing;
2. The date the Employee becomes eligible for similar benefits.

As used in this provision:

"Plant Closing" means a permanent cessation or reduction of business at a facility which results or will result as determined by the director in the permanent separation of at least 90% of the employees of said facility within a period of six months prior to the date of certification or with such other period as the director shall prescribe, provided that such period shall fall within the six month period prior to the date of certification.

"Partial Closing" means a permanent cessation of a major discrete portion of the business conducted at a facility which results in the termination of a significant number of the employees of said facility and which affects workers and communities in a manner similar to that of Plant Closings.

If an Employee leaves the group for a reason other than as a result of a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:

1. 31 days from the date the Employee leaves the group;
2. The date the Employee becomes eligible for similar benefits.

Minnesota residents:

Under the *Common Exclusions* section, the following changes are made:

- a) The exclusion related to intentionally self-inflicted Injury is replaced by the following:

intentionally self-inflicted Injury; and

- b) The exclusion related to operating a vehicle while under the influence of alcohol, or drugs is replaced with the following:

operating any type of vehicle while under the influence of alcohol, or any drug, or narcotic unless administered on the advice of a Physician and taken in accordance with the prescribed dosage, or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it.

"Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;

New Hampshire residents:

1) Under the *Claims Provisions* section, the following changes are made:

a) Under the Proof of Loss provision, the provision is replaced with the following:

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible.

b. The Time of Payment of Claims provision is replaced with the following:

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

c) Under the Payment of Claims provision, reference to “\$1,000” is changed to read “up to an amount not exceeding \$1,000”.

2) Under the *Administrative Provisions* section the following changes are made:

a. The Payment of Premium provision is replaced with the following:

Policyholder

The first premium is due on the Policy Effective Date. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder. If any premium is not paid on the Premium Due Date when due, this Policy will be cancelled as of such Premium Due Date, except as provided in the Policy Grace Period provision below.

b. The Grace Period provision is replaced with the following:

Policy

A Policy Grace Period of 31 days will be granted for payment of required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time this Policy was in force.

3) Under the *General Provisions* section, the following changes are made:

a. The following sentence has been added to the Assignment provision:

The rights and benefits under this Policy may not be assigned to a healthcare provider.

- b. The Incontestability provision is replaced with the following:

Incontestability

This Policy or Participation Under This Policy

All statements made by the Policyholder to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a signed copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for non-payment of premium.

A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a signed copy of the instrument containing the statement is, or has been, furnished to the claimant. After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for non-payment of premium.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

- c. Under the Policy Termination provision, reference to "31 days" is replaced with "45 days".
- 4) For purposes of *Continuation of Insurance Provision*, The term Spouse must also include a spouse who is widowed or divorced or legally separated from an Employee. See Spouse definition below:

The Employee's lawful spouse who is at least Age 18 but not yet Age 100. Except for purposes of determining initial eligibility, the term includes a spouse who is widowed or divorced or legally separated from an Employee.

- 5) The following Rider form(s) is/are not available:

WELLNESS/HEALTH SCREENING TEST AND PREVENTIVE CARE BENEFIT RIDER

Oregon residents:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

South Carolina residents:

- 1) Under the *Common Exclusions* section, the following changes are made:

- a. The following exclusions do not apply:

voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;

operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.

- b. The following exclusion is added:

Any loss resulting from being Intoxicated or under the influence of a narcotic unless taken on the advice of a Physician. "Intoxicated", for purposes of this exclusion, means intoxicated as defined by the law of the state in which the Covered Loss occurred.

- 2) Under the *Claim Provisions* section, the following changes are made:

- a. The Claimant Cooperation Provision does not apply.
- b. The Physical Examination and Autopsy provision is replaced with the following:

Physical Examination and Autopsy

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending. If an autopsy is performed, it will be in the State of South Carolina and during the period of contestability unless prohibited by law.

- c. The *Legal Actions* provision is replaced with the following:

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than six years after the time such written proof of loss must be furnished.

- 3) Under the *General Provisions* section, the Policy Termination provision is amended to include the following as last paragraph:

However, if the premium is to be collected in weekly, monthly, or other periodic installments by authority of a payroll deduction order executed by the Employee and delivered to Us or the Employer authorizing the deduction of premium installments from the Employee's salary or wages, We may not, during the period for which the Policy is issued and while the Employee remains employed by the authorized Employer, declare forfeited or lapsed the Policy until and unless a written or printed notice of the failure of the Employer to remit the premium or installment thereof, stating the amount or portion thereof due on the Policy and to whom it must be paid, has been duly addressed and mailed to the Employee who is insured under the Policy at least fifteen days before the Policy is terminated or lapsed.

South Dakota residents:

Under the *Common Exclusions* section, the following changes are made:

- a. The following exclusions do not apply:

voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;

operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.

- b. The following exclusion is amended, to not exclude treatment rendered by a family member:

services or treatment rendered by a Physician, Nurse or any other person who is:

- a. employed or retained by the Subscriber;
- b. providing homeopathic, aroma-therapeutic or herbal therapeutic services;

- c. The following exclusion is amended, to include "for which benefits are paid by Workers' Compensation or any similar law":

Injuries that occur in the workplace or during the course of any employment for pay, benefit, or profit for which benefits are paid by Workers' Compensation or any similar law.

Texas residents:

- 1) Under the *General Definitions* section, the Dependent Child definition is replaced with the following:

Dependent Child

An Employee's child who meets the following requirements:

- 1. A child who is less than 26 years old;
- 2. A child of any age who is dependent on an Employee, and is either medically certified as disabled, or is incapable of self-support due to mental retardation or physical handicap.

A child, for purposes of this provision, includes an Employee's:

- 1. natural child;
- 2. adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means a child of an Employee who is a party to a suit in which the Employee seeks to adopt the child, or the legally adopted child of the Employee's Spouse provided the child is living with, and is financially dependent upon the Employee;
- 3. stepchild who resides with the Employee and is financially dependent upon the Employee;
- 4. child for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns;
- 5. child for whom the Employee must provide medical support under an order issued under Chapter 154, Texas Family Code, or enforceable by a court in Texas;
- 6. grandchild, if the grandchild is under 26 years old and is a dependent of the Employee for Federal and State income tax return purposes at the time application for coverage of the grandchild is made. Coverage for the grandchild may not be terminated solely because the covered child is no longer a dependent of the Employee for Federal and State income tax return purposes.

- 2) Under the *Administrative Provisions* section, Change in Premium Rates Provision is modified by adding this first paragraph:

Changes in Premium Rates

The premium rates may be changed by the Insurance Company from time to time with at least 60 days advance written notice. The Insurance Company will not require a response from the Employer to renew the Policy, or take other action relating to the renewal or extension of the Policy, before the 45th day after the date such notice of the premium rate increase is given.

- 3) Under the *General Provisions* section, the first paragraph of the Policy Termination provision is replaced with the following:

We may terminate insurance, with 60 days advance written notice, on or after the first anniversary of the Policy Effective Date. The Subscriber or We may terminate insurance on any Premium Due Date. Written notice by certified mail notice must be given at least 60 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.

Vermont residents:

- 1) To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:
 - a. Civil Union Partner means:
 - i. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until: (1) the civil union is dissolved under applicable law; or (2) either the Employee or the Civil Union Partner marries another person.
 - b. Spouse means:
 - i. "Lawful spouse" and includes a lawful spouse of the same sex.
 - ii. This also includes a partner to a civil union recognized under Vermont Law.

2) Under the *Schedule of Benefits* section, the following changes are made:

- a) Portability provision has been removed from this schedule and has been replaced with the Continuation for Loss of Eligibility.

The following Continuation of Loss of Eligibility benefit periods have been added:

Loss of Eligibility

Maximum Benefit Period

Employee	to age 100
Spouse	to age 100
Dependent Children	to age 26

3) Under the *Termination of Insurance/Continuation of Insurance Provisions*, the following changes are made:

- a) Add the following to the Termination of Insurance provision:

For Continuation for Loss of Eligibility, the coverage on a Covered Person will end of the earliest date below due to a Qualifying Event:

at any time after 12 months if the Covered Person is considered to reside outside of the United States. The Covered Person will be considered to reside outside the United States when the Covered Person has been outside the United States for a total period of 12 months or more during any 12 consecutive months.

- b) Add the following provision to the *Continuation of Insurance* provision:

If an Employee is no longer in Active Service, coverage may be continued. The following provisions explain the continuation options available under this Policy. Please see the *Schedule of Benefits*, to determine the applicability of these benefits on a class level. Premiums are required for this coverage and are to be remitted in accordance with the *Payment of Premium* provision.

Continuation for Loss of Eligibility

If an Employee's coverage ends due to Loss of Eligibility from a qualifying event as defined in this section, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. The qualifying event means:

- 1. loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage;
- 2. divorce, dissolution, or legal separation of the covered employee from the employee's spouse or civil union partner;
- 3. a dependent child ceasing to qualify as a dependent child under the generally applicable requirements of the policy; or
- 4. death of the covered employee or member.

The Provisions of this section will not apply if

1. the deceased person or Employee was not insured under the group policy on the date of the qualifying event;
2. the person is covered by Medicare;
3. the person is covered by any other group insured or uninsured arrangement which provides dental coverage or hospital and medical coverage for individuals in a group and under which the person was not covered immediately prior to such qualifying event, and no preexisting condition exclusion applies.

Signed for the
Life Insurance Company of North America

A handwritten signature in cursive script that reads "William J. Smith". The signature is written in black ink and is positioned above the printed name.

William J. Smith, President

GAI-00-3000.00

**SUPPLEMENTAL INFORMATION
for**

University of Richmond (“Plan”)

**required by the Employee Retirement
Income Security Act of 1974**

As a Plan participant in University of Richmond's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in your Certificate are provided under a group insurance Policy issued by the Insurance Company. The Policy is incorporated into the Plan. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by University of Richmond, the Plan Sponsor.
- The Employer Identification Number (EIN) is 54-0505965.
- The Plan Number is 505.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, AI961270 (“Policy”), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA (“Insurance Company”).
- The Plan Administrator is:
University of Richmond
231 Richmond Way
UNIV. of Richmond, VA 23173
804-289-8167

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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 Employee Benefit Security Administration.

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 administrator may make a reasonable charge for the copies.

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.

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.

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 a Federal court. In such a 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 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, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your 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 Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

The Plan Administrator designates and names the Insurance Company the named fiduciary for deciding claims and appeals for benefits under the Plan. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by applicable law.

Claims for Disability Benefits (applies to all claims filed on or after April 1, 2018)

A disability “claim” is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is “filed” as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company’s intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant’s name and address, and the group Policy holder’s name and address. Properly filed claims will be decided with independence and impartiality.

The Insurance Company has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Insurance Company must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company’s decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant’s response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician’s name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the claimant’s adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request;

8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Insurance Company for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Insurance Company issues an adverse benefit decision on appeal, if the Insurance Company considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Insurance Company intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;

6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Claims for Non-Disability Benefits (applies to all claims filed on or after April 1, 2018)

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

The Insurance Company has 90 days from the date the claim is filed to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90 day period. If this should happen, the Insurance Company will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary; and
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

Appeal of Denied Non-Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, the Insurance Company will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
5. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

ER-03-2

**UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
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