



**BlueCross BlueShield**  
of Oklahoma

# **Voluntary Accident Insurance**

## **Employee Benefit Booklet**

**CITY OF TULSA**

**F024608-0001**

**Class 1-01**

**Plan 2**

# Dearborn Life Insurance Company

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

Administrative Office:

701 E. 22nd Street

Lombard, IL 60148

**Having issued Group Policy No. F024608**

(herein called the *Policy*)

to

**CITY OF TULSA**

(herein called the *Policyholder*)

## GROUP ACCIDENT INSURANCE CERTIFICATE

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

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

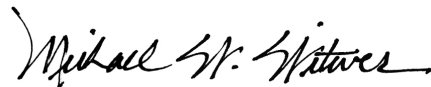
If the terms and provisions of this Group Insurance *Certificate* (issued to *You*) are different from the *Policy* (issued to the *Policyholder*), the *Policy* will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the *Policy*.

### READ THIS CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company



Secretary



President

### Voluntary Group Accident Insurance Certificate

with Dependent Accident Benefits

Non-Participating

**THIS IS AN ACCIDENT ONLY CERTIFICATE**

**THIS IS NOT A WORKERS' COMPENSATION POLICY**

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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## SCHEDULE OF BENEFITS

**POLICYHOLDER:** CITY OF TULSA  
**POLICY NUMBER:** F024608  
**POLICY EFFECTIVE DATE:** 01/01/2025  
**ANNUAL ENROLLMENT PERIOD:** October 1 - October 31

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**ELIGIBILITY:**  
**Class 01** All active full-time Employees, excluding Police and Fire of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Eligibility Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 30 per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.

**Eligibility Waiting Period:** Current *Employees*: First of the month following 30 Days of continuous, full-time Active Work

New *Employees*: First of the month following 30 Days of continuous, full-time Active Work

**Policyholder Contribution:** Voluntary Accident 0% of premium

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

**Dependent Benefit amounts  
unless otherwise stated:**

Spouse Benefits 100% of the *Employee's* benefit amount

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

**Coverage Type:** Group Accident Insurance Off the job coverage.

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

**Portability:**

Benefit Eligibility

Voluntary

Insured Eligibility

*Employee, Spouse, Dependent Child(ren)*

Portability Benefit Duration

To Age 65

## Accident Insurance Benefits

### Emergency Treatment Benefits

#### Accident Emergency Treatment Benefit

Emergency Room	\$200
Urgent Care Center	\$200
Physician's Office	\$200

**X-Ray Benefit** \$50

**Accident Follow-Up Treatment Benefit** \$50

**Hospital Admission Benefit** \$1,200

**Intensive Care Unit (ICU) Admission Benefit** \$2,000

**Hospital Confinement Benefit** \$250

**Intensive Care Unit (ICU) Confinement Benefit** \$500

### Accident Injury Benefits

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

#### **Burn Benefit**

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

At least 40 but less than 65	\$500	\$1,250
At least 65 but less than 160	\$750	\$3,750
At least 160 but less than 225	\$1,000	\$8,750
225 or more	\$1,250	\$12,500

<b>Skin Graft Benefit</b> as percentage of Burn Benefit	\$50%	\$50%
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#### **Eye Injury Benefit**

Surgical Repair	\$300
Removal of foreign body	\$65

#### **Laceration Benefit**

Laceration with no repair	\$35
Total of all lacerations with repair:	
Less than 5 cm	\$65
5 cm – 15 cm	\$250
Greater than 15 cm	\$500

<b>Fracture Benefit</b>	<b>Open Reduction</b>	<b>Closed Reduction</b>
Hip	\$5,000	\$2,000
Leg	\$3,000	\$1,000
Hand (excluding fingers)	\$1,500	\$500
Foot (excluding toes/heel)	\$1,500	\$500
Wrist	\$1,500	\$500
Elbow	\$1,500	\$500
Ankle	\$1,500	\$500
Kneecap	\$1,500	\$500
Shoulder blade	\$1,500	\$500
Forearm	\$1,500	\$500
Lower jaw	\$1,500	\$500
Vertebrae (body of)	\$2,000	\$700
Pelvis	\$2,000	\$700
Sternum	\$2,000	\$700
Upper jaw or face (excluding nose)	\$1,200	\$375
Upper arm	\$1,200	\$375

Rib	\$2,200	\$500
Nose	\$1,000	\$250
Heel	\$1,000	\$250
Finger	\$1,000	\$250
Coccyx	\$500	\$250
Toes	\$500	\$250
Vertebral Processes	\$3,000	\$400
Skull - depressed	\$3,500	\$1,875
Skull - simple	\$1,800	\$800
Chip Fracture (% of Closed Reduction)		25%
<b>Concussion</b>		\$150
<b>Dental Benefit</b>		
Broken tooth repaired with crown		\$400
Broken tooth resulting in extraction		\$130
<b>Coma Benefit</b>		\$12,500
<b>Paralysis Benefit</b>		
Quadriplegia		\$12,500
Paraplegia		\$6,250
Hemiplegia		\$4,750
<b>Surgical Benefits</b>		
<b>Surgical Procedure Benefit</b>		
Arthroscopy		\$300
Open abdominal		\$1,250
Cranial		\$1,250
Hernia		\$1,250
Thoracic Surgery		\$1,250
Repair of Tendon and/or Ligament		\$625
Repair of Torn Rotator Cuff		\$625
Repair of Ruptured Disc		\$625
Repair of Torn Knee Cartilage		\$625
<b>Miscellaneous Surgical Procedure Benefit</b>		
Surgery with General Anesthesia		\$300

Surgery with Conscious Sedation	\$120
<b>Outpatient Ambulatory Surgical Center Benefit</b>	
Increase to applicable Surgical or Miscellaneous Surgical benefit	20%

### **Additional Accident Benefits**

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

### **Wellness Benefit**

<b>Wellness Benefit</b>	\$150 per <i>Calendar Year</i> per <i>Covered Person</i>
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## ***ELIGIBILITY AND EFFECTIVE DATE PROVISIONS***

### ***Who is eligible for this insurance?***

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

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

### ***When does Your Contributory insurance become effective?***

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

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

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

### ***Change in Family Status***

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

***Change in Family Status*** means:

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

### ***When does Dependent coverage become effective?***

Your *Dependent's* coverage will become effective on the latest of:

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

### ***When does coverage for a new Spouse become effective?***

Coverage for a new *Spouse* starts automatically on Your marriage. Your new *Spouse* will be a *Covered Person* for 31 days. Your *Spouse* will cease to be a *Covered Person* unless:

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

### ***When does coverage for a newborn Child become effective?***

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

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

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

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

### ***What is an Annual Enrollment Period?***

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

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

### ***Eligibility after You Terminate Employment***

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

Exception: If *Your* coverage ends due to termination of employment and *You* return to *Active Work* for the *Policyholder* in an eligible class within 30 days, *We* will not apply a new *Eligibility Waiting Period* as defined in the *Schedule of Benefits*.

### ***Changes to Your coverage***

A change in *Your* coverage may occur if:

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

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

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

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

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

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

# **ACCIDENT INSURANCE BENEFITS**

## **Emergency Treatment Benefits**

### ***What is the Accident Emergency Treatment Benefit?***

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

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

### ***What is the X-Ray Benefit?***

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

### ***What is the Accident Follow-up Treatment Benefit?***

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

### ***What is the Hospital Admission Benefit?***

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

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

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

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

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

### ***What is the Hospital Confinement Benefit?***

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

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

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

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

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

## **Accident Injury Benefits**

### ***What are the Accident Injury Benefits?***

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

#### **Dislocation Benefit:**

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

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

#### **Burn Benefit**

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

#### **Skin Graft Benefit**

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

#### **Eye Injury Benefit**

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

#### **Laceration Benefit**

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

#### **Fracture Benefit**

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

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

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

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

### **Concussion Benefit**

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

### **Dental Benefit**

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

### **Coma Benefit**

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

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

The *Coma* must require intubation for respiratory assistance.

### **Paralysis Benefit**

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

## **Surgical Benefits**

### **Surgical Procedure Benefit**

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

### **Miscellaneous Surgical Procedure Benefit**

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

### **Outpatient Ambulatory Surgical Center Benefit**

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

## **Additional Accident Benefits**

### ***What is the Major Diagnostic Exams Benefit?***

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

### ***What is the Epidural Pain Management Benefit?***

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

### ***What is the Physical Therapy Benefit?***

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

### ***What is the Rehabilitation Unit Benefit?***

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

### ***What is the Appliance Benefit?***

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

### ***What is the Prosthesis Benefit?***

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

### ***What is the Blood/Plasma/Platelets Benefit?***

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

### ***What is the Ambulance Benefit?***

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

### ***What is the Transportation Benefit?***

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

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

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

### ***What is the Lodging Benefit?***

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

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

## ***LIMITATIONS AND EXCLUSIONS***

### Limitations:

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

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

### Exclusions:

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

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



## ***PORTABILITY BENEFIT***

### ***What is the Portability Benefit?***

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

The premiums for the coverage continued under the Portability Benefit will not be the same as the premium *You* are charged for *Your* group insurance under the *Policy*. Portability premium will be based on:

1. *Our* current rates for the applicant's age and class of risk at the time he elects Portability; and
2. the amount of insurance continued under Portability.

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

### ***What are Eligibility Requirements for Employee Portability?***

To be eligible for Portability, *You* must meet the following conditions:

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

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

We reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* misrepresented any of the information provided to support eligibility for Portability.

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

If *Dependent* coverage ceases, *You* or *Your* covered *Spouse* may elect Portability of *Dependent* coverage as follows:

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

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

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

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

We reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* or *Your Spouse* misrepresented any information provided to support eligibility for Portability of *Dependent* insurance.

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

### ***When will Portable Coverage Terminate?***

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

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

## ***TERMINATION PROVISIONS***

### ***When does Your coverage under the Policy end?***

Unless coverage is continued under the Portability Benefit, *Your* coverage terminates on the earliest of the following dates:

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

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

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

<b>Disability</b>	Until the end of the twelfth month following the month in which the <i>Disability</i> began, if all premiums are paid when due.
<b>Layoff</b>	Until the end of the month following the month during which the layoff began, if all premiums are paid when due.
<b>Leave of Absence</b>	Until the end of the twelfth month following the month during which the leave of absence began, if all premiums are paid when due, as governed by the <i>Policyholder's</i> Human Resource policy on family and medical leaves of absence or in accordance with the FMLA provision below.
<b>Labor Disputes</b>	Until the end of the twenty-fourth month following the month in which the labor dispute began, provided all premiums are paid when due
<b>Military Leave</b>	Until the end of the twelfth month following the month in which the military leave began, if all premiums are paid when due.
<b>Reserve National Guard</b>	<p>If <i>You</i> are a member of an organized United States Reserve Corps or National Guard Unit, coverage will continue while <i>You</i> are:</p> <ol style="list-style-type: none"><li>1. In attendance at annual field training, cruise or other active duty training period of less than 60 days (except while attending a service school lasting beyond 60 days, in which case coverage will extend for the duration of the school); or</li><li>2. on the way to or from such training; or</li><li>3. participating in an authorized periodic inactive duty training, assembly or other inactive duty training authorized by unit orders; or</li><li>4. participating as a member of <i>Your</i> unit in an authorized parade, exhibition or ceremony.</li></ol>

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

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

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

1. the leave period permitted by the federal FMLA; or
2. the leave period permitted by applicable state law.

*You* are eligible for leave under this Act in order to provide care:

1. After the birth of a *Child*; or
2. After the legal adoption of a *Child*; or
3. After the placement of a foster *Child* in *Your* home; or
4. To a *Spouse*, *Child* or parent due to their serious *Illness*; or
5. For *Your* serious health condition; or
6. For any event later added by amendment to the Act.

During *Your* FMLA period:

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

***When does Dependent coverage end?***

Unless insurance is continued under the Portability Benefit provision, *Dependent* coverage will end on the earliest of:

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

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

## ***GENERAL PROVISIONS***

### ***Entire Contract; Changes***

The Entire Contract consists of:

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

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

### ***Statements on the Application***

All statements made in any signed *Application*, or other written and signed statement, are considered representations and not warranties (absolute guarantees). No representation by:

1. the *Policyholder* in applying for the *Policy* will make it void unless the representation is contained in the signed *Application* or other written and signed statement; or
2. any *Employee* in enrolling for insurance under the *Policy* will be used to reduce or deny a claim unless a copy of the *Application for Insurance* or other written and signed statement, if applicable, has been signed by the *Employee* and has been given to the *Employee*.

### ***Legal Actions***

Unless otherwise provided by federal law, no legal action brought to recover on the *Policy* of any kind may be filed against *Us*:

1. until 60 days after proof of claim has been given; or
2. more than 3 years after proof of the *Accident* must be filed, unless the law in the state where *You* live allows a longer period of time.

### ***Clerical Error***

Clerical error or omission by *Us* to the *Policyholder* will not:

1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the *Policy*; or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about *You* that is incorrect, *We* will:

1. Use the facts to decide whether *You* have coverage under the *Policy* and in what amounts; and
2. Make a fair adjustment of the premium.

### ***Incontestability***

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

### ***Premium Provisions***

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

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

### ***Misstatement of Age***

If *You* have misstated *Your* age or the age of a *Dependent*, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

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

### ***Conformity with State Statutes and Regulations***

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

### ***Assignment***

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

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

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

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

### ***Retention of Discretion***

*We* shall have the exclusive right to interpret the terms of the *Policy*. The decision about whether to pay any claim, in whole or in part, is within *Our* discretion and such decisions shall be final and conclusive.

## **UNIFORM CLAIM PROVISIONS**

### ***Initial Notice of Claim***

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

### ***Telephonic Claim Notification***

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

### ***Claim Forms***

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

### ***Time Limit for Filing Your Claim***

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

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

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

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

### ***Physical Examination/Autopsy***

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

### ***Who will receive Your Insurance Benefits?***

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

### ***Facility of Payment***

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

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

### ***Do I have the Right to Appeal a Claim Denial?***

If *Your* claim is denied, in whole or in part, *You* will receive a written notice giving the following:

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

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

*You* may:

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

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

The decision on appeal will provide the following:

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



## ***GENERAL DEFINITIONS***

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

***Actively at Work*** or ***Active Work*** means that *You* must:

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

*You* will be considered ***Actively at Work*** if *You* were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); or
6. emergency leave of absence (except emergency medical leave); and
7. *You* were not *Hospital Confined* or disabled due to an *Injury* or *Illness*.

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

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

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

***Certificate*** means this *Accident Insurance Certificate*.

***Child(ren)*** means:

1. *Your* natural or step *Child* under the age stated in the Schedule of Benefits; or
2. a *Child* under the age stated in the Schedule of Benefits placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the *Child*. Eligibility will continue unless the *Child* is removed from placement; or
3. a *Child* of *Your Child* who is *Your* dependent for federal income tax purposes at the time application for coverage of the *Child* of *Your Child* is made.

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

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

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

***Dependent*** means:

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

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

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

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

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

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

**Hospital** means either of the following:

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

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

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

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

**Intensive Care Unit or ICU** means a place which:

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

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

An *Intensive Care Unit* that meets the definition above includes *Hospital* units with the following names:

- *Intensive Care Unit*;
- Coronary Care Unit;
- Neonatal *Intensive Care Unit*;
- Pulmonary Care Unit;
- Burn Unit; or
- Transplant Unit.

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

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

**Male Pronoun** whenever used includes the female.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A *Rehabilitation Unit* is not:

- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;

- a hospice care facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

**Spouse** means lawful *Spouse*.

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

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

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

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

**DEARBORN LIFE INSURANCE COMPANY**

**Chicago, Illinois**

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

***CERTIFICATE AMENDMENT***

This Amendment, effective 01/01/2025, is part of the Certificate to which it is attached. It is subject to all provisions of the Certificate not in conflict with the provisions of this Amendment.

**WELLNESS BENEFIT**

***What is the Wellness Benefit?***

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

***Wellness Tests*** include:

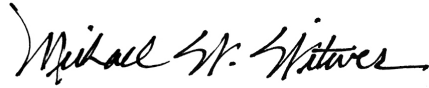
- Blood test for triglycerides;
- Bone marrow aspiration or biopsy;
- CA 15-3 (blood test for breast cancer);
- CA-125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Carotid Doppler;
- Chest x-ray;
- Colonoscopy;
- COVID-19 screening;
- Echocardiogram;
- Electrocardiogram;
- Fasting blood glucose test;
- Fasting plasma glucose (FPG);
- Flexible sigmoidoscopy;
- Hemoglobin A1C (HbA1c);
- Hemocult stool analysis;
- Mammography;
- Pap smear;
- PSA (blood test for prostate cancer);
- Serum cholesterol test to determine HDL and LDL levels;
- Serum protein electrophoresis (blood test for myeloma);
- Skin cancer biopsy;
- Stress test on a bicycle or treadmill;
- Thermography;
- Thin prep pap test;
- Two hour post-load plasma glucose; or
- Vaccinations; or
- Virtual colonoscopy.

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

For the purposes of the Wellness Benefit, Calendar Year is the period beginning January 1st and ending December 31st.

*The Wellness Tests* must be performed while the Insured's coverage under the Policy is in force. *Proof* must be provided that the test was performed and the Insured incurred an expense.

Nothing contained in this Amendment shall be held to alter or affect any provision or condition of your coverage other than as stated above.

A handwritten signature in black ink, reading "Michael S. Stivers". The signature is written in a cursive style with a large initial "M" and a long horizontal stroke at the end.

President

# NOTICE OF PROTECTION PROVIDED BY OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Oklahoma Life and Health Insurance Guaranty Association (“the Association”) and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
  - \$300,000 in death benefits
  - \$100,000 in cash surrender or withdrawal values
- Health Insurance
  - \$500,000 for health benefit plans (see definition below)
  - \$300,000 in disability income insurance benefits
  - \$300,000 in long-term care insurance benefits
  - \$100,000 in other types of health insurance benefits
- Annuities
  - \$300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is \$500,000.

“Health benefit plan” is defined in 36 O.S. §2024(7) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association’s website at [www.oklifega.org](http://www.oklifega.org), or contact:

Oklahoma Life & Health Insurance Guaranty Association  
201 Robert S. Kerr, Suite 600  
Oklahoma City, OK 73102

Oklahoma Department of Insurance  
3625 NW 56th Street, Suite 100  
Oklahoma City, OK 73112  
1-800-522-0071 or (405) 521-2828

**Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.**

**END OF CERTIFICATE**



Administrative Office:

**701 E. 22nd Street • Lombard, Illinois 60148**