United States Fire Insurance Company
5 Christopher Way, Eatontown, NJ 07724

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is attached to and made a part of the Policy/Certificate. The provisions of this Amendatory Endorsement are effective on the Effective Date and will expire concurrently with the Policy/Certificate, unless otherwise terminated. In consideration of issuance, the Policy/Certificate is hereby amended and modified, as follows:

Effective January 1, 2021, under Policy Number US1377134 for Financial Solutions Association, Inc., the Policy term is amended to read as follows:

Policy Effective Date:	January 1, 2021
Policy Expiration Date:	December 31, 2021
Policy Number:	US1515439

Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Policy/Certificate. If there is a conflict between the Policy/Certificate and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

Marc J. Adee
Chairman and CEO

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET ACCIDENT ONLY CERTIFICATE

POLICYHOLDER: Financial Solutions Association, Inc.

POLICY NUMBER: US1377134

POLICY EFFECTIVE DATE: January 1, 2020

POLICY EXPIRATION DATE: December 31, 2020

This Certificate is issued in the state of Illinois and shall be governed by its laws.

This Certificate contains a summary of the terms under which the Insurance Company agrees to insure certain persons and pay benefits under the Policy Number referenced above.

The Insurance Company and the Policyholder have agreed to all the terms of this Certificate.

10 DAY RIGHT TO RETURN THIS CERTIFICATE

If for any reason, you are not satisfied with this Certificate, you may return it to us within 10 days after receiving it. Upon its return, we will refund any premium paid and this Certificate will be deemed void, just as though it had never been issued.

THIS IS ACCIDENT ONLY COVERAGE.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS CERTIFICATE PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.

THIS CERTIFICATE IS NOT RENEWABLE.

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

Marc J. Adee
Chairman and CEO

James Kraus
Secretary

TABLE OF CONTENTS

The following provisions appear within this Certificate in the following order:

Schedule of Benefits

Definitions

Eligibility for Insurance

Effective Dates of Insurance

Termination Date of Insurance

Scope of Coverage

Description of Hazards

Description of Benefits

Exclusions

Aggregate Limit

Premium Provisions

General Provisions

Claim Provisions

SCHEDULE OF BENEFITS

BENEFIT PERIOD:	12 months and while the Policy is in force.
POLICY AGGREGATE BENEFIT AMOUNT:	$2,000,000
CLASS OF ELIGIBLE PERSONS:	Class 1: All active members of the policyholder with an active SmartHealth PayCard, including their Spouse and Dependent children.

ACCIDENTAL DEATH

Principal Sum:	$5,000
Time Period for Loss:	90 days

ACCIDENT MEDICAL EXPENSE BENEFIT

Lifetime Maximum for all Accident Medical	$100,000
Annual Maximum for all Accident Medical	$5,000
Maximum number of occurrences per Policy Year	3

ACCIDENT MEDICAL EXPENSE BENEFITS

Hospital Room & Board Daily Maximum Benefit:	**100% of the Semi-Private Room Rate up to $500**
Out-Patient Surgery Benefits:	
Outpatient Primary Surgeons Maximum Benefit Amount:	1**00% of URC up to $500**
Outpatient Assistant Surgeon Maximum Benefit:	**100% of URC up to $500**
Outpatient Surgical Facility Maximum Benefit	**100% of URC up to $500**
Emergency Room Benefit:	**100% of URC up to $500**
Air and Ground Ambulance Benefit Amount:	**100% of URC up to $500**

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Certificate. Additional terms may be defined within the provision to which they apply.

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

Aircraft means a vehicle which:
1. Has a valid certificate of airworthiness; and
2. Is being flown by a pilot with a valid license appropriate to the aircraft.

Benefit Period means the period of time from the date of Injury, as shown in the Schedule of Benefits.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for the Usual, Reasonable and Customary charges for the Medically Necessary treatment, services and supplies covered by the Policy and Certificate and which is performed or given under the direction of a Physician for treatment of an Injury. Coverage under the Policy and Certificate must remain continuously in force from the date of the Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained. A Covered Expense for a an Injury cannot be in excess of the maximum benefit amount payable per service as shown in the Schedule and cannot be for medical services and supplies that are excluded under the Policy.

Covered Person means a person eligible for coverage as identified in the Application for whom proper premium payment has been made, and who is therefore insured under this Certificate.

Dependent means the Insured's unmarried child who:
1. Has his principal residence with the Insured;
2. Chiefly relies on the Insured for support and maintenance; and
3. Is within the following age groups (unless otherwise shown in the Application):
    a. Under 19 years of age;
    b. 19 but less than 25 years of age and enrolled in a School as a full time student; or
    c. 19 or more years of age, and primarily supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap.

Child can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

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

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while this Certificate is in force.

He, his, and him includes she, her and hers.

Hospital means an institution which:
1. Is operated pursuant to law;
2. Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
3. Is under the supervision of a staff of Physicians;
4. Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
5. Has medical, diagnostic and treatment facilities, with major surgical facilities;
    a. On its premises; or
    b. Available to it on a prearranged basis; and
6. Charges for its services.
7. Is a duly licensed Rehabilitation Facility.

Hospital does not include:
1. A clinic or facility for:
    a. Convalescent, custodial, educational or nursing care;
    b. The aged, drug addicts or alcoholics;
2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
    a. The services are rendered on an emergency basis; and
    b. A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

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

Injury means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Immediate Family Member means the Covered Person's parent (includes step-parent), grandparent, Spouse, Child(ren) (includes legally adopted or step or Foster Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws. A Member of the Immediate Family includes an individual who normally lives in the Covered Person's household.

Medically Necessary or Medical Necessity means a treatment, service or supply that is:
1. Required to treat an Injury; and
2. Prescribed or ordered by a Physician or furnished by a Hospital;
3. Performed in the least costly setting required by the condition;
4. Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of alternative to be the Covered Expense.

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

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

Principal Sum means the largest amount payable under the benefit for all losses resulting from any one Accident.

Spouse means the lawful Spouse, if not legally separated or divorced, or Domestic Partner.

Usual, Reasonable and Customary means:
1. With respect to fees or charges, fees for medical services or supplies which are;
    a. Usually charged by the provider for the service or supply given; and
    b. The average charged for the service or supply in the locality in which the service or supply is received; or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

ELIGIBILITY FOR INSURANCE

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

EFFECTIVE DATES OF INSURANCE

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

Covered Person's Effective Date: A Covered Person will become an insured under this Certificate, provided proper premium payment is made, on the latest of:
1. The Effective Date of the Certificate; or
2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Schedule of Benefits.

TERMINATION DATE OF INSURANCE

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

The Policy terminates automatically on the earlier of:
1. The Policy Termination Date shown in the Policy; or
2. The premium due date if premiums are not paid when due subject to any grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate the Policy on the last day of the period for which premiums have been paid.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

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

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Termination:
Insurance for a Covered Person will end on the earliest of:
1. The date he is no longer in an Eligible Class.
2. The date he reports for active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    a. The date the premium is fully earned; or
    b. The Expiration Date of the Policy.
    This does not include Reserve or National Guard duty for training;
3. The end of the period for which the last premium contribution is made; or
4. The date the Policy is terminated.

Covered Person's Termination Date
Insurance for a Covered Person will end on the earliest of:

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

SCOPE OF COVERAGE

We will provide the benefits described in this Certificate to all Covered Persons who suffer a covered loss which:
1. Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS** and results, directly and independently of disease or bodily infirmity, from an Injury which is suffered in an Accident;
2. Occurs while the person is a Covered Person under this Certificate; and
3. Is within the scope of the risks set forth in the **DESCRIPTION OF HAZARDS** provisions.

Primary Medical Expense:
If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services on the SCHEDULE OF BENEFITS, we will pay the applicable benefit, subject to the Deductible Amount (if any).

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for treatment of a covered Injury:
1. While the person is insured under this Certificate; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Eligible Expense must be incurred within the time frame stated on the SCHEDULE OF BENEFITS.
The total of all medical benefits payable under this Certificate is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

DESCRIPTION OF HAZARDS

HAZARD: 24 HOUR COVERAGE (except pilots, crew members and Owned Aircraft)

We will pay the benefits described in this Certificate for any Accident which happens to a Covered Person while he is covered by this Certificate. This includes travel or flight in an Aircraft except as restricted below.

Exposure or Disappearance - This coverage includes exposure to the elements or disappearance after the forced landing, stranding, sinking or wrecking of a vehicle in which the Covered Person was traveling.

A Covered Person will be presumed to have died, for purposes of this coverage, if:
1. He is in a vehicle which disappears, sinks, or is stranded or wrecked; and
2. His body is not found within one year of the accident.

Aircraft Restrictions - If the accident happens while a Covered Person is riding in, or getting on or off, an Aircraft, we will pay benefits, but only if:
1. He is riding as a passenger, and not as a pilot or member of the crew; and
2. The aircraft is not being used for:
    a. Crop dusting, spraying, or seeding; fire firefighting; sky writing; sky diving or hang gliding; pipeline or power line inspection; aerial photography or exploration; racing, endurance tests, stunt or acrobatic flying; or
    b. Any operation which 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).

Unless otherwise stated, we will pay benefits for a covered loss, only once, even if coverage was provided under more than one Description of Hazards.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH
If, within 1 year from the date of an Accident covered by this Certificate, Injury from such Accident, results in Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

Loss	**Benefit Amount**
Loss of Life	$5,000

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles Benefit Periods, benefit maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:
1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 90 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Eligible Medical Expenses, from a Covered Accident, include:

1. **Hospital room and board expenses**: charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

2. **Out-Patient Surgery Benefits:**

   We will pay this benefit when the Covered Person requires Outpatient Surgery to treat a Covered Loss resulting directly and independently from all other causes from a Covered Accident. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

   Outpatient Surgery means the treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including the usual aftercare for such procedure, that is:
   a. necessary for treatment of the Covered Person; and
   b. given in the outpatient department of a Hospital or an ambulatory surgical center.

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

   Emergency Room treatment includes all hospital related services including physician, x-ray and lab services shown in the Schedule of Benefits.

4. **Air and Ground Ambulance** - for services billed by a professional ambulance company up to the Maximum Benefit Amount shown in Schedule of Benefits for the Ambulance benefit.

   Ground Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the injured from the scene of the Accident to a Hospital. Surface trips must be to the closest local facility that can provided the covered service appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area.

   Air transportation is covered when Medically Necessary because of a life threatening Injury. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the injured to the closest local facility available, coverage is for trips to the closest facility outside the local area.

AGE BASED REDUCTIONS

At age 65 or more, benefits for a Covered Person will be based on the following percentages of His Principal Sum in effect without this provision.

Age On Date of Loss	Percentage of Principal Sum
65 and over	15%

Premiums are based on the Principal Sum in force prior to applying the percentages in the above table.

EXCLUSIONS

This Certificate does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following unless otherwise covered under this Certificate by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty in any Armed Forces, National Guard, military, naval or air service or organized reserve corps:
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro-rata premium upon request;
5. Participation in a riot or insurrection.
6. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling, assault or battery.
7. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural foreseeable result of an Accidental external bodily injury or accidental food poisoning.
8. Disease or disorder of the body or mind.
9. Mental or nervous disorders.
10. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
11. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician and not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
12. Intoxication or being under the influence of any drug or narcotic.
13. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
14. Driving under the influence of a controlled substance unless administered on the advice of a Physician.
15. Driving while Intoxicated. Intoxicated will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.
16. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
17. Conditions that are not caused by a Covered Accident.
18. Covered Expenses for which the Covered Person would not be responsible in the absence of this Certificate.
19. Any treatment, service or supply not specifically covered by this Certificate.
20. Loss resulting from participation in any activity not specifically covered by this Certificate.
21. Charges which Are in excess of Usual, Reasonable and Customary charges.
22. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
23. Regular health check ups.
24. Services or treatment rendered by an Immediate Family member of the Covered Person;

25. Injuries paid under Workers' Compensation, Employers liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
26. That part of the medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any sate where prohibited).
27. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
28. Participation in any motorized race or speed contest.
29. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.
30. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
31. Damage or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Certificate.
32. Expense incurred for treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofascial pain, except as specifically provided in this Certificate.
33. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Certificate, and rendered within 6 months of the Accident.
34. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore.
35. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license.
36. Travel in or upon:
    a. Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
    b. Any off-road motorized vehicle not requiring licensing as a motor vehicle; when used for recreation.
37. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    a. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    b. While being used for any test or experimental purpose; or
    c. While piloting, operation, learning to operate or serving as a member of the crew thereof; or
    d. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    e. an ultralight hang-gliding, parachuting, or bungee-cord jumping

    Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.
38. Treatment for an Injury that is caused by or results from a nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
    a. The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy and
    b. The Covered Person was within a 25-mile radius of the site of release either:
        i. At the time of the release; or
        ii. Within 24 hours of the start of the release
39. The repair or replacement of existing artificial limbs, orthopedic braces or orthotic devises.
40. Rest cures or custodial care.
41. Prescription medicines unless specifically provided for under this Certificate.
42. Elective or Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
43. Massage Therapy, Physical Therapy or Acupuncture/Acupressure Services, unless otherwise specifically allowed for in the Schedule of Benefits.
44. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto} of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

AGGREGATE LIMIT

The Aggregate Limit Amount is shown on the Schedule of Benefits. We will NOT be liable for any amount over such limit for any one Accident.

If the total amount of benefits to be paid under this Certificate is more than the Aggregate Limit Amount, the benefit amount payable for a Covered Person's loss will be determined as a proportionate share of the Aggregate Limit Amount.

PREMIUM PROVISIONS

GRACE PERIOD:
A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period unless notice has been sent, in accordance with the POLICY TERMINATION provision, of the intent to terminate coverage under this Certificate. Coverage will end if the premium is not paid by the end of the grace period.

PREMIUMS:
Premium due dates are the first of every month. Premium payment made in advance or for more than a one month period will not affect any provisions of this Certificate with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

CHANGES IN RATES:
We have the right to change the premium rates on any premium due date:
1. After the first 12 months insurance is in effect;
2. Coinciding with a change in the coverage provided or classes eligible; or
3. Coinciding with a change in the risks we have assumed.

We will give 31 days written notice of any change under 1. above. Notice will be sent to the Policyholder's most recent address in our records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
This Certificate, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at our option, may also be made a part of this contract.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2 years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

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

WORKERS' COMPENSATION INSURANCE:
This Certificate is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

RECORDS MAINTAINED:
The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person's insurance under this Certificate.

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

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

POLICY TERMINATION:
We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

CONFORMITY WITH STATE STATUTES:
Any provision of this Certificate in conflict, on the Effective Date of this Certificate, with the laws of the state where it is delivered, is amended to conform to the minimum requirements of such laws.

CLAIM PROVISIONS

NOTICE OF CLAIM:
Written notice must be given to us within 30 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given at our administrative office as shown on the cover page or to our agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

CLAIM FORMS:
When we receive the notice of claim, we will send forms for filing proof of loss. If claim forms are not sent within 30 days after notice is given, the proof requirements will be met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:
Written proof of loss must be furnished to us in the case of a claim for loss for which this Certificate provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

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

If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

TIME OF PAYMENT OF CLAIMS:
Benefits due under this Certificate for a loss, other than a loss for which this Certificate provides installments, will be paid immediately upon receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which this Certificate provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

PAYMENT OF CLAIMS:
Benefits for a Covered Person's loss of life will be paid to the beneficiary named in our records, if any, at the time of payment. The benefits can be paid in one sum or, at a Covered Person's written request, in accordance with one of our settlement plans. If a Covered Person has not requested any settlement plan, the beneficiary can do so in writing after a Covered Person's death. If there is no named beneficiary or surviving beneficiary, a Covered Person's loss of life benefits will be paid in one sum to the first surviving class of following in the order shown below:

1. The beneficiary named to receive a Covered Person's proceeds;
2. Spouse;
3. Child or children;
4. Mother or father;
5. Sisters or brothers; or
6. The estate of a Covered Person.

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

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

PAYMENT OF CLAIMS: OTHER BENEFITS:
All other benefits will be paid to the Covered Person, if he is living, if not, we will pay his beneficiary or his estate.

CHANGE OF BENEFICIARY: (Applicable only if an Accidental Death or Dismemberment benefit is provided)
The Insured can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change which a Covered Person may make unless the designation of beneficiary is irrevocable or otherwise required by law.

CONDITIONAL CLAIM PAYMENT:
If a Covered Person incurs expenses for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will pay benefits if:

1. The Covered Person first agrees in writing to refund the lesser of:
    a. The amount we actually paid for such expenses; or
    b. The amount actually received from the third party for such expenses; and

2. The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, prior to our payment of benefits under this Certificate, if the third party's liability is satisfied in an amount less than the benefits payable under this Certificate, we will pay the difference.

PHYSICAL EXAMINATION AND AUTOPSY:
We will pay the cost and have the right to have the Covered Person examined as often as reasonably necessary while the claim is pending. We can have an autopsy made at our expense unless prohibited by law. (Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.)

LEGAL ACTIONS:
No action at law or in equity shall be brought to recover benefits under this Certificate less than 60 days after written proof of loss has been furnished as required by this Certificate. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

UNITED STATES FIRE INSURANCE COMPANY

Administrative Office: 5 Christopher Way, Eatontown, NJ 07724

ILLINOIS AMENDATORY RIDER

(Applicable to **Illinois** Residents Only)

This Amendatory Rider is attached to and made part of the Policy/Certificate. The provisions of this Amendatory Rider are effective on the Effective Date and will expire concurrently with the Policy/Certificate, unless otherwise terminated.

The Policy/Certificate is hereby amended for Illinois as follows:

1. The definition of "Accident" in the section entitled "DEFINITIONS" is modified to read:

"Accident" means an event which:

(1) Causes Injury to one or more Covered Persons; and

(2) Occurs while coverage is in effect for the Covered Person.

2. The following Exclusion of the EXCLUSIONS section has been expanded.

12. Intoxication or being under the influence of any drug or narcotic.

Intoxication means that which id defined and determined by the laws of the jurisdiction where the loss or cause of the loss was incurred.

3. The following Exclusion of the EXCLUSION section have been revised:

8. Disease or disorder of the body.

4. Exclusion # 9 of the EXCLUSION section has been deleted in its entirety:

9. Mental or nervous disorders.

5. The EXCLUSIONS section of the Policy/Certificate has been expanded to include the following LIMITATIONS PROVISION:

LIMITATIONS

Any benefits payable under this Certificate will be limited to the following:

(1) The medical benefits otherwise payable under this Certificate will be reduced by 50% if:
   (a) Excess insurance is provided under this Certificate; and
   (b) The Covered Person has coverage under another plan providing medical expense benefits; and
   (c) The other plan is an HMO, PPO or similar arrangement ("PPO-Preferred Provider Organization" means an Organization offering health care services through designated health care providers who agree to perform these services at rates lower than nonpreferred providers.); and
   (d) The Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement for the provision of benefits.

   The Covered Person's limitation does not apply to emergency treatment required within 24 hours after an Accident which occurred outside the geographic area serviced by the HMO, PPO or similar arrangement.

(2) In the event no consenting surgical opinion is obtained for those procedures that mandate such second surgical opinion benefits payable for all Eligible Expenses associated with the procedure will be reduced by 50%. This limitation will apply whether the surgery is performed on an in-patient or out-patient basis. We will not cover a second opinion given more than 6 months after surgery was first recommended.

(3) Costs that exceed the Usual, Reasonable and Customary charges in the area where the services are furnished or supplies provided. Services, supplies and equipment must be:
   (a) Medically necessary for the care or treatment of a covered Injury;

(b) Received while coverage is in force under this Certificate; and
(c) Rendered and/or prescribed by a licensed Physician other than the Covered Person (or a member of his household or immediate family) in accordance with current medical standards and practices.

(4) The application of the Coordination of Benefits or Non-Duplication of Benefits provision.

(5) If the Covered Person is admitted into the Hospital on a Friday or a Saturday on a non-emergency basis and the procedure for which he is admitted is not performed on the day of or the day after admission, we will not pay the Hospital charges for room and board or miscellaneous Hospital charges for the initial Friday or Saturday preceding the procedure.

6. The AGGREGATE LIMIT section is replaced by the following:

AGGREGATE LIMIT

The Aggregate Limit Amount is shown on the Schedule of Benefits. We will NOT be liable for any amount over such limit for any one Accident. This Aggregate Limit Amount is only applicable if the Policyholder pays the entire premium. It is not applicable if the Covered Person pays any portion of the premium.

If the total amount of benefits to be paid under this Policy is more than the Aggregate Limit Amount, the benefit amount payable for a Covered Person's loss will be determined as a proportionate share of the Aggregate Limit Amount. Benefits payable will be paid immediately upon the Company's receipt of due written proof of loss. If not paid within 30 days following receipt of due written proof of loss, interest will be payable at the rate of 9% per annum from the 30th day after receipt of such proof of loss, to the date of late payment. Interest amounting to less than one dollar will not be payable.

7. The TIME OF PAYMENT OF CLAIMS provision of the CLAIMS PROVISION section is replaced by the following:

TIME OF PAYMENT OF CLAIMS:
Benefits due under this Policy for a loss, other than a loss for which this Policy provides installments, will be paid immediately upon receipt of due written proof of such loss. If not paid within 30 days following receipt of due written proof of loss, interest will be payable at the rate of 9% per annum from the 30th day after receipt of such proof of loss, to the date of late payment. Interest amounting to less than one dollar will not be payable.

Subject to written proof of loss, all accrued benefits for loss for which this Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

If there is a conflict between the Policy/Certificate and this Rider, the terms of this Rider will govern.

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

Signature

Marc J. Adee
Chairman and CEO

Signature

James Kraus
Secretary

Illinois Guaranty Notice

Title 50, Chapter I, Subchapter 11, Part 3401 of the Illinois Insurance Code requires all Group Life and Health insurers to provide a summary of the basic provisions of the Illinois Life and Health Insurance Guaranty Association Law.

Any questions concerning this summary should be directed to the Illinois Life and Health Guaranty Association or to the Illinois Insurance Department at the addresses contained in the summary.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
1520 Kensington Road, Suite 112
Oak Brook, IL 60523
(773) 714-8050
http://www.ilhiga.org

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515
http://www.insurance.illinois.gov

SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") 215 ILCS 5/531.01, et seq.. The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

a) Coverage:
The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:
   1) Direct non group life insurance, health insurance, annuity and supplemental contracts;
   2) life, health, annuity certificates under direct group policies or contracts;
   3) unallocated annuity contracts; and
   4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

b) 1) the insurer that issued the policies or contracts domiciled in Illinois; and
   2) the states in which the persons reside have associations similar to the Illinois Association; and
   3) the persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in that state at the time specified in that state's guaranty association law.

c) Exclusions from Coverage:
   1) The Guaranty Association does not provide coverage for:
      A) any policy or portion of a policy for which the individual has assumed the risk;
      B) any policy of reinsurance (unless an assumption certificate was issued);
      C) interest rate guarantees which exceed certain statutory limitations;
      D) any unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of the contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
      E) any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery.
      F) any policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto;
      G) any portion of a policy or contract to the extent that the assessments required by Section 531.09 of this Code with respect to the policy or contract are preempted or otherwise not permitted by federal or State law;
      H) any portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:
         a) a multiple employer welfare arrangement as defined in 29 U.S.C. Section 1144;
         b) a minimum premium group insurance plan;
         c) a stop loss group insurance plan; or
         d) an administrative services only contract.
      I) any portion of a policy or contract to the extent that it provides for:
         a) dividends or experience rating credits;
         b) voting rights; or
         c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service or administration of the policy or contract;

J) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or

K) any contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is to an affiliate of the member insurer;

L) any portion of a policy or contract to the extent that it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this Code, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this Section, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of the impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; or

M) any stop loss insurance.

2) In addition, persons are not protected by the Guaranty Association if:

A) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or

B) their policy was issued by an organization which is not a member insurer of the Association was not licensed or did not have a certificate of authority to issue the policy or contract in this State.

d) Limits on Amount of Coverage:

1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty's Association's liability is limited to the lesser of either:

A) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or

B) with respect to any one life, regardless of the number of policies, contracts, or certificates:

i) in the case of life insurance, $300,000 in death benefits but nor more than $100,000 in net cash surrender or withdrawal values;

ii) in the case of health insurance:

a) $100,000 for coverages not defined as disability insurance or basic hospital, medical, and surgical insurance or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values;

b) $300,000 for disability insurance and $300,000 for long-term care insurance as defined in Section 351 A-1 of this Code; and

c) $500,000 for basic hospital medical and surgical insurance and major medical insurance;

iii) with respect to annuities 250,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $250,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.

e) However, in no event is the Guaranty Association liable for more than (1) in aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual.

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

United States Fire Insurance Company

GRIEVANCE PROCEDURES

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

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

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

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

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

FORMAL GRIEVANCE PROCEDURE

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

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

First Level Review

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

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

Grievance

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

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

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the Frist Level Review for an Adverse Determination. Within 10 business days after receiving a request for a Second Level Review, we will advise you of the following:

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

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

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

The panel must be comprised of persons who:

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

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

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

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

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

EXPEDITED REVIEW

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

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

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

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

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

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

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

Your Privacy is Our Concern

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

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

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

What do we do with the information collected about you?

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

To whom do we disclose information about you?

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

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

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

How to contact Us

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

Privacy Policy Coordinator
Crum & Forster A&H Division
5 Christopher Way, 2nd Floor
Eatontown, New Jersey 07724