

RELIANCE STANDARD

LIFE INSURANCE COMPANY

Home Office: Chicago, Illinois • Administrative Office: Philadelphia, Pennsylvania

POLICYHOLDER: Old National Bancorp

POLICY NUMBER: VAI 825591

EFFECTIVE DATE: January 1, 2016

ANNIVERSARY DATES: January 1, 2017 and each January 1st thereafter.

PREMIUM DUE DATES: The first premium is due on the Effective Date. Further premiums are due monthly, in advance, on the first day of each month.

This Policy is delivered in Indiana and is governed by its laws and/or the Employee Retirement Income Security Act of 1974 ("ERISA") as amended, where applicable.

This insurance Policy is a contract between you, the Policyholder named above, and us, Reliance Standard Life Insurance Company. We agree to provide insurance to you in exchange for the payment of premium and the signed Application. This Policy insures against certain accidental losses as described herein. It will cover the Eligible Persons for whom the proper premium has been paid for the Benefit Amounts shown on the Schedule of Benefits. Coverage is subject to the terms and conditions of this Policy. In the event of a conflict between this Policy and the Certificate, the terms of this Policy control.

The Effective Date of this Policy is shown above. Insurance starts and ends at 12:01 A.M., local time, at your address. It stays in force in accordance with the provisions set forth in this Policy. The "POLICY TERMINATION" section of the GENERAL PROVISIONS explains when this Policy can be ended.

This Policy is signed by our President and Secretary.


Secretary


President

**READ THIS POLICY CAREFULLY. THIS POLICY PROVIDES LIMITED BENEFITS. THIS POLICY IS NOT A
MEDICAL INSURANCE POLICY.**

THIS POLICY IS OPTIONALLY RENEWABLE.

**GROUP ACCIDENT POLICY
NON-PARTICIPATING**

APPLICATION FOR GROUP ACCIDENT POLICY

**RELIANCE STANDARD LIFE INSURANCE COMPANY
PHILADELPHIA, PENNSYLVANIA**

GROUP POLICY NUMBER: VAI 825591 **POLICY EFFECTIVE DATE:** January 1, 2016
POLICY DELIVERED IN: Indiana **ANNIVERSARY DATE:** January 1st in each year
APPLICATION IS MADE TO US BY: Old National Bancorp

This Application is completed in duplicate, one copy is attached to your Policy and the other is to be returned to us.
It is agreed that this Application takes the place of any previous application for your Policy.

Signed at: _____ This: _____ Day of: _____

Policyholder: _____

Federal Employer Identification Number: 35-1539838

By: _____
(Signature)

(Title)

Please sign and return.





*BC1COAPVAI 82559101/01/2016*RSL
*BC2COAPOld National Bancorp

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SCHEDULE OF BENEFITS

NAME OF SUBSIDIARIES, DIVISIONS OR AFFILIATES TO BE COVERED: ALL

"Affiliate" means any corporation, partnership, or sole proprietor under the common control of the Policyholder.

ELIGIBILITY: Each active, Full-time Employee, except any person employed on a temporary or seasonal basis.

SERVICE WAITING PERIOD: 1 month of continuous employment.

INDIVIDUAL EFFECTIVE DATE: The first day of the month coinciding with or next following the date an Eligible Person completes his/her enrollment form.

INDIVIDUAL REINSTATEMENT: 6 months

MINIMUM PARTICIPATION REQUIREMENTS: Number of Insureds: 10

COVERAGE TYPE: On and Off-the-Job (24 hour coverage)

The employee and spouse must be under age 70 to enroll for insurance coverage.

CHANGES IN BENEFIT AMOUNTS: Increases in the Benefit Amounts for any reason are effective on the date of the change, provided the Insured is Actively at Work on the effective date of the change. If the Insured is not Actively at Work when the change would otherwise take effect, the change will take effect on the day after the Insured has returned to Active Work for one (1) full day.

Decreases in the Benefit Amounts are effective on the date of the change.

CONTRIBUTIONS:	Each Eligible Person:	100%
	Each Eligible Person and Dependent spouse:	100%
	Each Eligible Person and Dependent child(ren):	100%
	Each Eligible Person and Dependents:	100%

Receipt of benefits under this Policy may be taxable. It is recommended that the Insured contact his/her personal tax advisor.

BENEFIT AMOUNTS: Eligible for Plan A

PLAN A

EMERGENCY CARE BENEFITS:

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Air Ambulance Transportation	\$500
Ambulance Transportation	\$100
Emergency Treatment	\$150
Diagnostic Examination	\$100
Initial Physician Office Visit	\$50

GENERAL TREATMENT BENEFITS:

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Initial Hospital Admission	\$500
Initial Intensive Care Unit (ICU) Hospital Admission	\$1,000
Hospital Confinement	\$200 per day
Intensive Care Unit (ICU) Confinement	\$400 per day
Rehabilitation Facility Confinement	\$50 per day
Follow-up Physician Office Visit	\$50
Transportation	\$300
Lodging	\$100 per day

SPECIFIED COVERED INJURY AND TREATMENT BENEFITS:

<u>Type of Benefit</u>	<u>Benefit Amount</u>	
	<u>Surgical</u>	<u>Non-Surgical</u>
Fractures:		
Ankle	\$600	\$300
Arm	\$600	\$300
Bones of Face	\$300	\$150
Coccyx	\$300	\$150
Collarbone	\$600	\$300
Elbow	\$600	\$300
Finger	\$100	\$50
Foot	\$600	\$300
Hand	\$600	\$300
Hip	\$3,200	\$1,600
Kneecap	\$600	\$300
Leg	\$1,600	\$800
Jaw	\$600	\$300
Nose	\$300	\$150
Pelvis	\$1,600	\$800
Rib	\$300	\$150
Shoulder Blade	\$600	\$300
Skull (Except bones of face or nose – Depressed)	\$5,000	\$2,500
Skull (Simple)	\$1,500	\$750
Sternum	\$600	\$300
Toe	\$100	\$50
Vertebrae	\$600	\$300
Vertebral Column	\$1,600	\$800
Wrist	\$600	\$300
Chip Fractures	25% of Benefit Amount for non-surgical full fracture	
Multiple Fractures	100% of the highest Benefit Amount for any one fracture among all fractures sustained	
Dislocations:		
Ankle	\$1,200	\$600
Collarbone	\$1,200	\$600
Elbow	\$600	\$300
Finger	\$200	\$100
Foot	\$1,200	\$600
Hand	\$600	\$300
Hip	\$3,200	\$1,600
Knee	\$2,000	\$1,000
Lower Jaw	\$600	\$300
Shoulder	\$600	\$300
Toe	\$200	\$100
Wrist	\$600	\$300
Partial Dislocation	25% of Benefit Amount for non-surgical full dislocation	
Multiple Dislocations	100% of the highest Benefit Amount for any one dislocation among all dislocations sustained	

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Blood, Plasma and Platelets:	\$200
Burns:	
<u>2nd Degree Burns</u>	
Covering less than 10% of the body	\$100
Covering 10% but less than 25% of the body	\$200
Covering 25% but less than 35% of the body	\$400
Covering 35% (or greater) of the body	\$800
<u>3rd Degree Burns</u>	
Covering less than 10% of the body	\$800
Covering 10% but less than 25% of the body	\$1,600
Covering 25% but less than 35% of the body	\$3,200
Covering 35% (or greater) of the body	\$6,400
<u>Skin Grafts (due to Burns)</u>	25 % of the Benefit Amount payable for Burns
Coma:	\$5,000
Concussion:	\$100
Dental Injury:	
Extraction	\$50
Crown	\$150
Eye Injury:	
Removal of Foreign Object	\$100
Surgical Repair	\$200
Lacerations:	
No Sutures Required	\$25
Sutures Required (Total length of all sutured Lacerations):	
Less than 2" long	\$50
2" but less than 6" long	\$200
6" long or greater	\$400
PARALYSIS BENEFITS:	
Paraplegia or Hemiplegia	\$5,000
Quadriplegia	\$10,000

Type of Benefit**Benefit Amount****SURGERY BENEFITS:**

Exploratory Surgery (No Repair)	\$100
Knee Cartilage (Surgically Repaired)	\$300
Abdominal or Thoracic Surgery (Surgically Repaired)	\$1,000
Ruptured Disc (Surgically Repaired)	\$500
Tendon, Ligament or Rotator Cuff (Surgically Repaired):	
One Repair:	\$300
Two or more Repairs:	\$600

TRANSITIONAL BENEFITS:

Medical Appliance	\$100
Prosthesis:	
One:	\$500
Two or more:	\$1,000
Physical Therapy (per session)	\$25

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:**Loss of Life:**

Employee	\$25,000
Spouse	\$12,500
Child(ren)	\$5,000 per child

Loss of Life on a Common Carrier: 100% of Loss of Life

Loss of one of the following: 50% of Loss of Life

Hand
Foot
Arm
Leg
Sight in One Eye
Hearing in One Ear

Loss of finger, thumb or toe:

One Loss	\$250
Two or more Losses	\$750

Catastrophic Loss as follows:

Speech 100% of Loss of Life
Two or more Losses, except the Loss of fingers, thumbs or toes

Wellness Benefit: \$50

For Insureds age 65 and over, the Benefit Amount for Accidental Death and Dismemberment, Common Carrier and Catastrophic Loss Benefits is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Benefit Amount will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 65 or over on their Individual Effective Date.

Age	Percentage of available or in force amount at age 64
65-69	50%
70+	25%

The Dependent spouse Benefit Amount for Accidental Death and Dismemberment, Common Carrier and Catastrophic Loss Benefits will reduce in the same manner as the Insured's Benefit amount upon the Dependent spouse's attainment of the reducing age(s).

Child Benefit Amounts will not reduce.

DEFINITIONS

"Actively at Work" and "Active Work" means the Insured is actually performing on a Full-time basis each and every duty pertaining to his job working for you in the place where and the manner in which the job is normally performed. This includes approved time off for vacation, jury duty and funeral leave, but does not include time off as a result of injury or sickness.

"Burns" means:

- (1) 2nd degree burns, which are those that have burned through the first layer of skin as well as the second layer of skin (dermis); and
- (2) 3rd degree burns, which are those that have burned through all layers of the skin and causes permanent tissue damage; and

cover a specific percentage of the body as shown on the Schedule of Benefits.

"Catastrophic Loss" means two or more Losses, as defined, excluding the Loss of a finger, thumb or toe or any combination thereof. Loss of speech is considered catastrophic without an accompanying Loss.

"Coma" means a state of profound unconsciousness, from which one cannot be aroused, that lasts continuously for at least a period of one hundred sixty-eight (168) hours requiring confinement in a Hospital under the care of a Physician, board certified as a neurologist. The Physician's diagnosis must be supported by a Glasgow Coma Scale score of no greater than seven (7) or a score of Level V or less on the Rancho Los Amigos Scale throughout the one hundred sixty-eight (168) hour period and an abnormal Electroencephalogram (EEG).

"Common Carrier" means any:

- (1) aircraft operated under a license for hire for the transportation of passengers; or
- (2) land conveyance licensed for hire for the transportation of passengers.

"Concussion" means a blow to the head that results in loss of consciousness, confusion, loss of memory or generally being dazed.

"Covered Accident" means an accident or event that:

- (1) could not have been foreseen, anticipated or expected;
- (2) occurs while the Insured's or Insured Dependent's coverage is in force under this Policy;
- (3) occurs on or off the job;
- (4) results in Injury for which benefits may be payable; and
- (5) is not excluded under the terms of this Policy.

"Dentist" means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which such license was issued.

"Dependents" means:

- (1) the Insured's legal spouse; and
- (2) the Insured's child(ren), from birth to 26 years, including natural children, legally adopted children, children who are dependent on the Insured during the waiting period before adoption, stepchildren, foster children and children under legal guardianship of the Insured; and
- (3) the Insured's child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on the Insured for more than 50% of their total support.

"Dislocation" means complete displacement of a bone from its normal articulation with a joint, also called luxation. Partial Dislocation is an incomplete displacement of a bone from its normal articulation with a joint, also called subluxation.

"Eligible Person" means a person who meets the Eligibility Requirements of this Policy.

"Fracture" means a bone that is broken which is diagnosed by a Physician. A Chip Fracture means that a fragment of bone has been broken off.

"Full-time" means working for you for a minimum of 20 hours during a person's regularly scheduled work week.

"Glasgow Coma Scale" means a system for assessing the severity of brain impairment in an individual with a brain injury that uses the sum of scores given for eye-opening, verbal, and motor responses. A high score of fifteen (15) indicates no impairment and a score of seven (7) or less indicates severe impairment.

"Hospital" means a legally operated, accredited facility licensed to provide full-time care and treatment for the condition for which benefits are payable under this Policy. It is operated with a full-time staff of Physicians and registered nurses. It does not include facilities that primarily provide custodial or rehabilitative care, education, or long-term institutional care on a residential basis.

"Hospital Confinement/Confined" means that the Insured or Insured Dependent has been formally admitted to a Hospital on the advice of a Physician and remains in the Hospital more than twenty-three (23) hours.

"Immediate Family" means the parents, siblings, spouse or children of the Insured or Insured Dependent.

"Injury" means bodily injury to the Insured or Insured Dependent resulting directly from an accident independent of all other causes, which occurs while such Insured's or Insured Dependent's coverage under this Policy is in force.

"Inpatient" means that the Insured or Insured Dependent has been admitted to a Hospital on the advice of a Physician and remains in the Hospital more than twenty-three (23) hours.

"Insured" means a person employed by the Policyholder who meets the Eligibility Requirements of this Policy and is enrolled for this insurance.

"Insured Dependent" means a "Dependent", as defined, whose insurance under this Policy is in effect.

"Intensive Care Unit (ICU)" means a specific area of the Hospital, set apart from the surgical recovery room and other rooms used for confinement of patients, providing:

- (1) intensive medical care and treatment to only those patients who are in critical condition;
- (2) continuous observation of and care to patients by a specially trained nursing staff that is dedicated exclusively to the ICU on a twenty-four (24) hour basis;
- (3) a Physician assigned exclusively to the ICU on a full-time basis; and
- (4) life-saving equipment required to treat patients in critical condition which is permanently located in the ICU.

"Loss" as used in the Dismemberment and Catastrophic Loss benefits, means severance or total and irrecoverable loss of:

- (1) the hand or foot through or above the wrist or ankle joint;
- (2) the arm above the elbow;
- (3) the leg above the knee;
- (4) a finger, thumb or toe, including at least one joint, which is either partially or completely severed;
- (5) sight in an eye in which the corrective visual acuity is worse than 20/200 or the field of vision is 20 degrees or less;
- (6) hearing that cannot be corrected to any degree by any procedure or device; or
- (7) speech which cannot be corrected to any degree by any procedure or device,

which results directly and independently from an Injury with no other contributing cause.

"Medical Appliance" means an appliance that assists the Insured or the Insured Dependent with mobility such as crutches, wheel chairs, or walkers.

"Medical Professional" means a person, other than a Physician, that provides medical care and services within the scope of his or her license such as physician's assistants, nurse practitioners and registered nurses.

"Outpatient" means an Insured or Insured Dependent who receives medical care, treatment and services when not confined in a Hospital on an Inpatient basis.

"Paralysis" means Paraplegia, Quadriplegia or Hemiplegia diagnosed by a Physician and as defined below:

- (1) "Paraplegia" means complete and permanent loss of motor function of both lower limbs.
- (2) "Quadriplegia" means complete and permanent loss of motor function of both the upper and lower limbs.
- (3) "Hemiplegia" means complete and permanent loss of motor function of the upper and lower limbs of the same side of the body.

"Physician" means a duly licensed medical or osteopathic doctor who is recognized by the law of the state in which treatment is provided as qualified to treat the type of Injury for which claim is made. The Physician may not be the Insured or a member of his/her Immediate Family.

"Rancho Los Amigos Scale" means a system used by the medical profession for measuring levels of awareness, cognition, behavior and interaction with the environment. A score of Level VII means no impairment and a Level V or less indicates severe impairment.

"Rehabilitation Facility" means any facility or Hospital that is licensed in the state in which it is operating to provide rehabilitation services, therapy or retraining to the Insured or Insured Dependent to enable him or her to walk, communicate, and/or function as a member of society.

"Therapist" means an individual:

- (1) licensed to practice physical or occupational therapy in the state in which therapy is provided; and
- (2) providing services within the scope of his or her license.

"We", "us", and "our" means Reliance Standard Life Insurance Company.

"You", "your", and "yours" means the Policyholder.

CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER

For the purposes of this Policy, you as the Policyholder, act on your behalf or as the employee's agent. Under no circumstances will you be deemed our agent.

Compliance With Americans With Disabilities Act (ADA)

It is your responsibility to establish and maintain procedures which comply with the employer responsibilities of the Americans With Disabilities Act of 1990, as amended.

Compliance With The Employee Retirement Income Security Act (ERISA)

It is your responsibility to establish and maintain procedures which comply with the employer and/or Plan Administrator responsibilities of ERISA and the accompanying regulations, where applicable.

Distribution Of Certificates Of Insurance

Certificates of Insurance will be provided to you for Insureds covered under this Policy. The Certificate will outline the insurance coverage, and explain the provisions, benefits and limitations of this Policy. It is your responsibility to distribute the appropriate Certificates and any updates or other notices from us to each Insured.

Maintenance Of Records

It is your responsibility to maintain sufficient records of each Insured's insurance, including additions, terminations and changes. We reserve the right to examine these records at the place where they are kept during normal business hours or at a place mutually agreeable to you and us. Such records must be maintained by you for at least three (3) years after this Policy terminates.

Reporting Of Eligibility And Coverage Amounts

It is your responsibility to notify us on a timely basis of all individuals eligible for coverage under this Policy, of all individuals whose eligibility for coverage ends and of all changes in individual coverage amounts.

It is your responsibility to provide accurate census information on all Insureds on or before each Anniversary Date, if we request such information.

Timely Payment Of Premiums

It is your responsibility to pay all premiums required under this Policy when due. Any change in the premium contribution basis must be approved by us.

Premium Rate Changes

It is your responsibility to provide advance notice to Insureds in the event of any applicable rate change that would impact their premium contribution.

GENERAL PROVISIONS

ENTIRE CONTRACT: The entire contract between you and us is this Policy, your signed Application for this Policy (a copy of which is attached at issue), and any endorsements or amendments.

CHANGES: No agent has the authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, signed by a President, Vice President or Secretary and attached to this Policy.

INCONTESTABILITY: Any statement made in your application will be deemed a representation, not a warranty. We cannot contest this Policy after it has been in force for two (2) years from the date of issue, except for non-payment of premium.

Any statements made by you, any Insured or any Insured Dependent, or on behalf of any Insured or any Insured Dependent to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the Benefit Amount for which an Insured or any Insured Dependent is covered. The following rules apply to each statement:

- (1) No statement will be used in a contest unless:
 - (a) it is in a written form signed by the Insured or any Insured Dependent, or on behalf of any Insured or any Insured Dependent; and
 - (b) a copy of such written instrument is or has been furnished to the Insured or any Insured Dependent, the Insured's or any Insured Dependent's beneficiary, or legal representative.
- (2) If the statement relates to an Insured's or any Insured Dependent's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two (2) years during the lifetime of the Insured or any Insured Dependent. Also, we will not use such statements to contest a benefit increase after such benefit increase has been in force for two (2) years during the Insured's or any Insured Dependent's lifetime.

ASSIGNMENT: The benefits under this Policy may not be assigned, except as required by law.

RECORDS MAINTAINED: You or an authorized Plan Administrator must maintain records of all Insureds. Such records must show the essential data of the insurance, including new persons, terminations, changes, etc. This information must be reported to us regularly. We reserve the right to examine the insurance records maintained at the place where they are kept. This review will only take place during normal business hours.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by you, us, or the Plan Administrator:

- (1) will not terminate insurance that would otherwise have been effective; and
- (2) will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

MISSTATEMENT OF AGE: If an Insured's or Insured Dependent spouse's age has been misstated, benefits will be those that apply to his/her correct age.

NOT IN LIEU OF WORKERS' COMPENSATION: This Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

CONFORMITY WITH STATE LAWS: Any provision in this Policy which, on its Effective Date, is in conflict with the laws in the state where it is issued or in a state that otherwise has jurisdiction over such provision, is amended to conform with the minimum requirements of such laws of that state.

CERTIFICATE OF INSURANCE: Certificates of insurance will be provided to you for Insureds covered under this Policy. The certificate will outline the insurance coverage and to whom benefits are payable.

POLICY TERMINATION: You may cancel this Policy at any time. This Policy will be cancelled on the date we receive your letter or, if later, the date requested in your letter.

We may cancel this Policy:

- (1) if the premium is not paid at the end of the grace period; or
- (2) if the number of Insureds (excluding Dependents) covered is less than the Minimum Participation Number on the Schedule of Benefits; or
- (3) on any Policy Anniversary after coverage has been in force for twelve (12) months.

If we cancel because of (1) above, this Policy will be cancelled at the end of the grace period. If we cancel because of (2) or (3) above, we will give you thirty-one (31) days written notice prior to the date of cancellation.

You will still owe us any premium that is not paid up to the date this Policy is cancelled. We will return any part of the premium paid beyond the date this Policy is cancelled.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

GENERAL GROUP: The general group will be your employees and employees of any subsidiaries, divisions or affiliates named on the Schedule of Benefits.

ELIGIBLE CLASSES: The eligible classes will be those persons described on the Schedule of Benefits.

ELIGIBILITY REQUIREMENTS: A person is eligible for insurance under this Policy if he/she:

- (1) is a member of an Eligible Class, as shown on the Schedule of Benefits page; and
- (2) has completed the Service Waiting Period, as shown on the Schedule of Benefits page.

SERVICE WAITING PERIOD: A person who is continuously employed on a Full-time basis with you for the period specified on the Schedule of Benefits has satisfied the Service Waiting Period.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If you pay the entire premium, the insurance of an Eligible Person will go into effect on the date stated on the Schedule of Benefits. If an Eligible Person pays a part of the premium, he/she must apply in writing for the insurance to go into effect. He/she will become insured on the later of:

- (1) the Individual Effective Date as shown on the Schedule of Benefits; or
- (2) the first day of the month coinciding with or next following the date he/she applies; or
- (3) the date premium is remitted.

Changes in the Insured Benefit Amount are effective as shown on the Schedule of Benefits.

If an Eligible Person is not Actively At Work on the day his/her insurance is to go into effect, the insurance will go into effect on the day he/she returns to Active Work for one full day.

TERMINATION OF INDIVIDUAL INSURANCE: An Insured's coverage will terminate on the first of the following to occur:

- (1) the date this Policy terminates;
- (2) the last day of the Policy month in which the Insured ceases to be in a class eligible for this insurance;
- (3) the end of the period for which premium has been paid; or
- (4) the date the Insured enters military service (not including Reserves or National Guard).

Any Loss which occurs prior to the termination of this insurance coverage will not be affected.

CONTINUATION OF INDIVIDUAL INSURANCE: The insurance of the Insured and any Insured Dependents may be continued, by payment of premium, beyond the date the Insured ceases to be eligible for this insurance, but not longer than:

- (1) twelve (12) months, if due to sickness or Injury; or
- (2) one (1) month, if due to temporary lay-off or approved leave of absence.

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if a former Insured has been:

- (1) on an approved leave of absence; or
- (2) on temporary lay-off.

The former Insured must return to Active Work with you within the period of time shown on the Schedule of Benefits. He/she must also be a member of a class eligible for this insurance.

The former Insured will not be required to fulfill the Eligibility Requirements of this Policy again. The insurance will go into effect on the date he/she returns to Active Work. However, if the former Insured returns after having resigned or having been discharged, he/she will be required to fulfill the Eligibility Requirements of this Policy again.

BENEFIT PROVISIONS

We will pay one or more of the following benefits as listed under Emergency Care Benefits, General Treatment Benefits, Specified Covered Injury and Treatment Benefits, Paralysis Benefits, Surgery Benefits, Transitional Benefits and Accidental Death and Dismemberment Benefits if the Insured or Insured Dependent sustains an Injury due to a Covered Accident and meets all of the requirements defined for payment under a specific benefit. Please refer to the Schedule of Benefits for benefit amounts payable.

EMERGENCY CARE BENEFITS:

Air Ambulance Transportation: An Air Ambulance Transportation benefit will be payable should the Insured or Insured Dependent sustain an Injury as a result of a Covered Accident if:

- (1) a licensed ambulance company provides air transport:
 - (a) to or from a Hospital; or
 - (b) between medical facilities; and
- (2) the air ambulance transportation is provided within forty-eight (48) hours of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident. This benefit may be payable in addition to an Ambulance Transportation benefit.

Ambulance Transportation: An Ambulance Transportation benefit will be payable should the Insured or Insured Dependent sustain an Injury as a result of a Covered Accident if:

- (1) a licensed ambulance company provides ground transport:
 - (a) to or from a Hospital; or
 - (b) between medical facilities; and
- (2) ground transportation is provided within ninety (90) days of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident. This benefit may be payable in addition to an Air Ambulance Transportation benefit.

Emergency Treatment: An Emergency Treatment benefit will be payable should the Insured or Insured Dependent sustain an Injury as a result of a Covered Accident if:

- (1) he or she is examined or treated in a Hospital emergency room or urgent care facility; and
- (2) emergency treatment is received within seventy-two (72) hours of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Diagnostic Examination: A Diagnostic Examination benefit will be payable if the Insured or Insured Dependent must undergo one of the following diagnostic examinations as prescribed by a Physician due to Injury sustained as a result of a Covered Accident:

- (1) Computed Tomography (CT or CAT) scan;
- (2) Magnetic Resonance Imaging (MRI);
- (3) Positron Emission Tomography (PET) scan; or
- (4) Single Photon Emission Computed Tomography (SPECT) scan.

Such examination must be performed within sixty (60) days of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Initial Physician Office Visit: An Initial Physician Office Visit benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident and is examined or treated by a Physician or Medical Professional in such individual's office. Examination or treatment must be provided within sixty (60) days of the Covered Accident.

This benefit is not payable if the Insured or Insured Dependent is eligible to receive a benefit under Emergency Treatment.

Only one (1) benefit will be paid for each person insured per Covered Accident.

GENERAL TREATMENT BENEFITS:

Initial Hospital Admission: An Initial Hospital Admission lump sum benefit will be payable if the Insured or Insured Dependent sustains an Injury due to a Covered Accident and requires admission to a Hospital if:

- (1) admission occurs within one hundred eighty (180) days of the Covered Accident; and
- (2) the Hospital stay is more than twenty-three (23) hours; and
- (3) it is the first Hospital admission for such Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

This benefit will not be payable if:

- (1) treatment is given in the emergency room; or
- (2) treatment is provided on an Outpatient basis.

If a benefit is payable under the Initial Hospital Admission benefit as well as under the Initial Intensive Care Unit (ICU) Hospital Admission benefit, only one (1) benefit will be paid, which is the highest.

The Insured or Insured Dependent may also be eligible for a Hospital Confinement benefit.

Initial Intensive Care Unit (ICU) Hospital Admission: An Initial ICU Hospital Admission lump sum benefit will be payable if the Insured or Insured Dependent sustains an Injury due to a Covered Accident and requires admission to the ICU of a Hospital if:

- (1) admission occurs within one hundred eighty (180) days of the Covered Accident;
- (2) the ICU stay is more than twenty-three (23) hours; and
- (3) it is the first ICU admission for such Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

If a benefit is payable under the Initial Intensive Care Unit (ICU) Hospital Admission benefit as well as under the Initial Hospital Admission benefit, only one (1) benefit will be paid, which is the highest.

The Insured or Insured Dependent may also be eligible for an Intensive Care Unit (ICU) Confinement benefit.

Hospital Confinement: A Hospital Confinement benefit will be payable for each day the Insured or Insured Dependent is confined in a Hospital because an Injury is sustained due to a Covered Accident if the initial confinement begins within one hundred eighty (180) days of the Covered Accident.

This benefit is payable per day for up to three hundred sixty-five (365) days for each person insured per Covered Accident over the course of three hundred sixty-five (365) days from the date of initial Hospital Confinement.

Only one (1) Hospital Confinement benefit is payable regardless of whether more than one Covered Accident caused such confinement.

If a Hospital Confinement benefit and an Intensive Care Unit (ICU) Confinement benefit are both payable on the same day, only the ICU Confinement benefit will be paid for that day. A Hospital Confinement benefit and an Intensive Care Unit (ICU) Confinement benefit may both be payable for one Hospital stay but are payable based on where the Insured or Insured Dependent is on any given day.

Intensive Care Unit (ICU) Confinement: An ICU Confinement benefit will be payable for each day the Insured or Insured Dependent is confined in the ICU of a Hospital because of an Injury sustained due to a Covered Accident if confinement begins within thirty (30) days of the Covered Accident.

This benefit will be payable for up to thirty (30) days for each person insured per Covered Accident over the course of three hundred sixty-five (365) days from the date of initial ICU confinement.

Only one (1) ICU Confinement benefit is payable regardless of whether more than one Covered Accident caused such confinement. If an ICU Confinement benefit and a Hospital Confinement benefit are both payable on the same day, only the ICU Confinement benefit will be paid for that day. An ICU Confinement benefit and a Hospital Confinement benefit may both be payable for one Hospital stay but are payable based on where the Insured or Insured Dependent is on any given day. If the Insured or Insured Dependent exhausts the ICU Confinement benefit before such confinement is over, a Hospital Confinement benefit may be payable.

Rehabilitation Facility Confinement: A Rehabilitation Facility Confinement benefit will be payable for each day the Insured or Insured Dependent is confined in a Rehabilitation Facility because of Injury sustained due to a Covered Accident if confinement begins within one hundred eighty (180) days of the Covered Accident.

This benefit is payable per day for up to thirty (30) days for each person insured per Covered Accident over the course of three hundred sixty-five (365) days from the date of initial Rehabilitation Facility Confinement.

Only one (1) Rehabilitation Facility Confinement benefit is payable regardless of whether more than one Covered Accident caused such confinement. The Rehabilitation Facility Confinement benefit is not payable for any day that the Insured or Insured Dependent receives benefits under the Hospital Confinement or ICU Confinement benefits.

Follow-up Physician Office Visit: A Follow-up Physician Office Visit benefit will be payable for follow-up examination or treatment by a Physician or Medical Professional in such individual's office if the Insured or Insured Dependent has sustained an Injury as a result of a Covered Accident. Examination or treatment must be provided within sixty (60) days of the Covered Accident.

This benefit is not payable while the Insured or Insured Dependent is confined in a Hospital, ICU or Rehabilitative Facility.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Transportation: A Transportation benefit will be payable should the Insured or Insured Dependent sustain an Injury due to a Covered Accident if:

- (1) he or she must travel more than one hundred (100) miles one way for treatment at a Hospital or other medical facility;
- (2) the treatment is prescribed by a Physician;
- (3) the treatment is not available locally; and
- (4) transportation is by bus, train, airplane or medical transportation vehicle.

This benefit is payable for up to three (3) round trips for treatment for each person insured per Covered Accident.

The Transportation benefit is not payable if transport is provided by ambulance or air ambulance.

Lodging: A Lodging benefit is payable for each day a friend, caregiver or family member travels more than one hundred (100) miles away from his or her home to support the Insured or Insured Dependent who is Hospital confined because of an Injury sustained due to a Covered Accident. The friend, caregiver or family member must temporarily reside in a hotel, motel or hospital-sponsored lodging. Lodging benefits will be payable for one (1) person.

This benefit is payable for up to thirty (30) days within three hundred sixty-five (365) days of the Covered Accident.

SPECIFIED COVERED INJURY AND TREATMENT BENEFITS:

Fracture: A Fracture benefit will be payable if the Insured or Insured Dependent sustains a Fracture or Chip Fracture as a result of a Covered Accident provided it is diagnosed by a Physician within ninety (90) days of the Covered Accident.

If the Insured or Insured Dependent sustains more than one (1) fracture as a result of such Covered Accident, we will pay one (1) benefit, which is the highest.

Dislocation: A Dislocation benefit will be payable if the Insured or Insured Dependent sustains a dislocation or partial dislocation as a result of a Covered Accident provided it is diagnosed by a Physician within ninety (90) days of the Covered Accident.

If the Insured or Insured Dependent sustains more than one (1) dislocation as a result of such Covered Accident, we will pay one (1) benefit, which is the highest.

Blood, Plasma and Platelets: A Blood, Plasma and Platelet benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident requiring a transfusion of blood, plasma or platelets provided such transfusion is administered within ninety (90) days of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Burns: A Burn benefit will be payable if the Insured or Insured Dependent sustains a 2nd or 3rd degree burn as a result of a Covered Accident provided treatment is received from a Physician within seventy-two (72) hours of the Covered Accident.

If the Insured or Insured Dependent sustains Burns in more than one (1) classification as shown on the Schedule of Benefits, only one (1) Burn benefit, which is the highest, will be paid for each person insured per Covered Accident.

Skin Graft (due to Burns): A Skin Graft benefit will be payable if the Insured or Insured Dependent requires skin grafting as a result of a Burn sustained in a Covered Accident and was paid a benefit under the Burn benefit.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Coma: A Coma benefit will be payable if the Insured or Insured Dependent is in a Coma, as diagnosed by a Physician, for one hundred sixty-eight (168) hours as a result of a Covered Accident. However, benefits will not be paid when a Coma has been medically induced.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Concussion: A Concussion benefit will be payable if the Insured or Insured Dependent sustains a Concussion as a result of a Covered Accident provided it is diagnosed by a Physician within seventy-two (72) hours of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Dental Injury: A Dental Injury benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident to his or her natural teeth which requires:

- (1) extraction; or
- (2) repair by insertion of a crown.

Initial treatment must be provided by a Dentist within seven (7) days of the Covered Accident.

Only one (1) benefit will be paid for each person insured per Covered Accident.

Eye Injury: An Eye Injury benefit will be payable if the Insured or Insured Dependent sustains an Injury to his or her eye or eyes as a result of a Covered Accident provided a Physician:

- (1) performs surgical repair on the eye or eyes within ninety (90) days of a Covered Accident; or
- (2) removes a foreign object from the eye or eyes within ninety (90) days of the Covered Accident.

Only one (1) benefit will be paid for each eye for each person insured per Covered Accident.

Lacerations: A Laceration benefit will be payable if the Insured or Insured Dependent is Injured as a result of a Covered Accident and sustains a laceration (cut), provided it is treated by a Physician or Medical Professional within seventy-two (72) hours of the Covered Accident.

This benefit is payable:

- (1) once for the total number of lacerations received not requiring sutures (stitches); and
- (2) once for the total length of all lacerations received requiring sutures,

for each person insured as a result of any one (1) Covered Accident.

If a laceration would normally require sutures but the Physician or Medical Professional chooses to repair the laceration by some other medically accepted method, the benefit will still be payable as if the repair was made with sutures.

PARALYSIS BENEFITS:

Paralysis: A Paralysis benefit will be payable if the Insured or Insured Dependent sustains an Injury due to a Covered Accident that results in Paralysis if:

- (1) the Insured or Insured Dependent loses the function of two or more limbs for an uninterrupted period of sixty (60) days; and
- (2) such Paralysis is confirmed by a Physician.

The uninterrupted sixty (60) day period of Paralysis is waived if clinical and radiological evidence shows that the spinal cord has been transected with no possibility of returned functionality.

SURGERY BENEFITS:

Exploratory Surgery: An Exploratory Surgery benefit will be payable for exploratory surgery for the procedures listed under Surgery Benefits if such surgery is performed and no repair is done.

Only one (1) benefit will be payable for each person insured per Covered Accident.

Knee Cartilage: A Knee Cartilage benefit will be payable if the Insured or Insured Dependent sustains torn cartilage in the knee due to a Covered Accident if the Injury is:

- (1) treated by a Physician within seventy-two (72) hours of the Covered Accident; and
- (2) repaired or removed through surgery by a Physician within three hundred sixty-five (365) days of the Covered Accident.

Only one (1) benefit will be payable per knee for each person insured per Covered Accident.

Abdominal or Thoracic Surgery: An Abdominal or Thoracic Surgery benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident that is diagnosed as requiring abdominal or thoracic surgery and is, indeed, surgically treated by a Physician within seventy-two (72) hours of the Covered Accident.

Only one (1) benefit will be payable for each person insured per Covered Accident.

Ruptured Disc: A Ruptured Disc benefit will be payable if the Insured or Insured Dependent sustains a ruptured disc in the spine as a result of a Covered Accident requiring surgical repair if the Injury is:

- (1) treated by a Physician within sixty (60) days of the Covered Accident; and
- (2) repaired surgically by a Physician within three hundred sixty-five (365) days of the Covered Accident.

Only one (1) benefit will be payable for each person insured per Covered Accident.

Tendon, Ligament, Rotator Cuff: A Tendon, Ligament, Rotator Cuff benefit will be payable if the Insured or Insured Dependent sustains an Injury to tendons, ligaments or rotator cuffs as a result of a Covered Accident requiring surgical repair if the Injury is:

- (1) treated by a Physician within sixty (60) days of the Covered Accident; and
- (2) repaired surgically by a Physician within one hundred eighty (180) days of the Covered Accident.

This benefit will be payable for up to two (2) surgically repaired tendons, ligaments or rotator cuffs, or any combination thereof, for each person insured per Covered Accident.

TRANSITIONAL BENEFITS:

Medical Appliance: A Medical Appliance benefit will be payable if the Insured or Insured Dependent sustains an Injury as a result of a Covered Accident which requires a Medical Appliance to assist him or her with mobility provided such appliance is prescribed by a Physician or Medical Professional and received by the Insured or Insured Dependent within three hundred sixty-five (365) days of the Covered Accident.

If the Injury sustained is considered a Catastrophic Loss as defined, the Medical Appliance must be prescribed by a Physician or Medical Professional and received by the Insured or Insured Dependent within two (2) years of the Covered Accident.

Only one (1) benefit is payable for each person insured per Covered Accident.

Prosthesis: A Prosthesis benefit will be payable if the Insured or Insured Dependent requires a prosthetic limb as a result of Injury sustained due to a Covered Accident if such prosthesis is prescribed by a Physician and received by the Insured or Insured Dependent within three hundred sixty-five (365) days of the Covered Accident.

If the Injury sustained is considered a Catastrophic Loss as defined, a Physician must prescribe the prosthesis and the Insured or Insured Dependent must receive it within two (2) years of the Covered Accident.

Only one (1) benefit is payable per limb, up to two (2) limbs, for each person insured per Covered Accident.

Physical Therapy: A Physical Therapy benefit will be payable should the Insured or Insured Dependent sustain an Injury as a result of a Covered Accident which requires therapy if it:

- (1) is prescribed by a Physician;
- (2) is provided by a Therapist;
- (3) is performed in an office, Hospital or Rehabilitation Facility on an Inpatient or Outpatient basis;
- (4) begins within ninety (90) days of the Covered Accident; and
- (5) is completed within three hundred sixty-five (365) days of the Covered Accident.

This benefit is payable for up to six (6) therapy sessions for each person insured per Covered Accident.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:

Accidental Death and Dismemberment: An Accidental Death and/or Dismemberment benefit will be payable in accordance with the Schedule of Benefits if the Insured or Insured Dependent sustains an Injury due to a Covered Accident that results in death or dismemberment Loss, if death or dismemberment Loss occurs within three hundred sixty-five (365) days of the Covered Accident.

A Dismemberment benefit will be payable if a body part listed on the Schedule of Benefits as a Loss is surgically re-attached.

If a Catastrophic Loss benefit is payable for a Covered Accident, no benefit will be payable under this benefit for the same Loss.

Common Carrier: A Common Carrier benefit will be payable in addition to the Accidental Death Benefit if the Insured or Insured Dependent sustains an Injury due to a Covered Accident on a Common Carrier, as defined, which results in death within three hundred sixty-five (365) days of the Covered Accident.

Catastrophic Loss: A Catastrophic Loss benefit will be payable if the Insured or Insured Dependent sustains an Injury due to a Covered Accident that results in a Catastrophic Loss if such Loss occurs within three hundred sixty-five (365) days of the Covered Accident. The benefit payable is shown on the Schedule of Benefits.

If a Catastrophic Loss benefit is payable for a Covered Accident, no benefit will be payable under the Accidental Dismemberment benefit for the same Loss. The total benefit payable under this benefit cannot exceed that of the Accidental Death benefit.

WELLNESS BENEFIT

We will pay the Insured the amount shown on the Schedule of Benefits for one (1) health screening test performed during a twelve (12) month period for the Insured and his/her Insured Dependents* provided he/she:

- (1) supplies written proof satisfactory to us that such a health screening test has been performed; and
- (2) was covered under this Policy at the time the test was performed; and
- (3) has not already had one of the following health screening tests performed at any time during the same twelve (12) month period.

Health screening tests covered under this Policy are:

- (1) Stress test on a bicycle or treadmill;
- (2) Fasting blood glucose test;
- (3) Blood test for triglycerides;
- (4) Serum cholesterol test to determine level of HDL and LDL;
- (5) Bone marrow testing;
- (6) Breast ultrasound;
- (7) CA 15-3 (blood test for breast cancer);
- (8) CA 125 (blood test for ovarian cancer);
- (9) CEA;
- (10) Chest X-ray;
- (11) Colonoscopy;
- (12) Flexible sigmoidoscopy;
- (13) Hemoccult stool analysis;
- (14) Mammography;
- (15) Pap smear;
- (16) PSA (blood test for prostate cancer); and
- (17) Serum Protein Electrophoresis (blood test for myeloma)

*Only one (1) Wellness Benefit will be paid in a twelve (12) month period for all Insured Dependent children as a group.

The Wellness Benefit is paid in addition to any other payments the Insured or Insured Dependent may receive under this Policy.

DEPENDENT INSURANCE

Nothing in this section will change or affect any of the terms of this Policy other than as specifically set out in this section. All the Policy provisions not in conflict with these provisions shall apply to this section.

When an Insured Dependent sustains an Injury due to a Covered Accident we will pay the applicable benefit shown on the Schedule of Benefits. Only dependents that meet the definition of Dependent can be insured for this benefit.

Any benefit payable for an Insured Dependent will be paid to the Insured unless another individual has been designated as beneficiary.

A person may not have coverage under this Policy both as an Insured and as an Insured Dependent. Only one eligible spouse may cover the eligible children as Insured Dependents. Dependents may be covered as Insured Dependents if not covered as an Insured. If insurance is in force for an Insured Dependent child, any newly eligible Dependent child(ren) will be automatically covered.

ELIGIBILITY: An Eligible Person is eligible to enroll his/her eligible Dependents on the date he/she becomes an Insured.

EFFECTIVE DATE OF DEPENDENT INSURANCE: If you pay the entire premium for Dependents, a Dependent's insurance will become effective on the later of:

- (1) the first day of the month coinciding with or next following the date the Insured becomes eligible for Dependent Insurance; or
- (2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent.

If you require an Insured to pay a portion of the Dependent premium for Dependent insurance, he/she may insure his/her Dependents by making written application. In this case, the insurance for Dependents will take effect on the later of:

- (1) the first day of the month coinciding with or next following the date the Insured becomes eligible for Dependent insurance; or
- (2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent, if application is made on or before that date; or
- (3) the first day of the month coinciding with or next following the date of application; or
- (4) the date the premium applicable to the coverage selected is remitted.

Changes in the Insured Dependent's Benefit Amount are effective as shown on the Schedule of Benefits.

TERMINATION OF DEPENDENT INSURANCE: The insurance for an Insured Dependent will terminate on the first of the following dates:

- (1) the date this Section terminates;
- (2) the end of the period for which premium for Dependent insurance has been paid;
- (3) the date the Insured's insurance terminates; or
- (4) the date the dependent is no longer a Dependent as defined.

NEWLYWED PROVISION: At the marriage of an Insured who had not previously elected Dependent spouse coverage, his/her new spouse shall automatically become an Insured Dependent spouse.

Such spouse shall be an Insured Dependent spouse for thirty-one (31) days. He/she shall then cease to be an Insured Dependent spouse unless:

- (1) the Insured requests, in writing and within such thirty-one (31) day period, continuation of such Dependent spouse coverage; and
- (2) the additional premium is paid for such coverage.

NEWBORN CHILDREN: If a child is born to an Insured who has not elected Dependent child(ren) coverage, such child shall be an Insured Dependent child from the moment of birth.

The newborn child shall be an Insured Dependent child for thirty-one (31) days. He/she shall then cease to be an Insured Dependent child unless:

- (1) the Insured requests, in writing and within such thirty-one (31) day period, continuation of such Dependent child(ren) coverage; and
- (2) the additional premium is paid for such coverage.

The above coverage will also be extended to newly adoptive children from the earlier of: 1) the date of placement for the purpose of adoption; or 2) the date of the entry of an order granting the adoptive parent custody of the child for the purposes of adoption. Such coverage shall continue unless the placement is disrupted prior to legal adoption and the child is removed from placement, provided notice and payment of any required premium is paid within thirty-one (31) days from the date in (1) or (2) above. The above coverage will be extended to foster or stepchildren, as of the date they become financially dependent on an Insured for support, provided they otherwise meet the definition of a Dependent.

**EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES
EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

Family and Medical Leave of Absence:

We will continue the Insured's coverage and that of any Insured Dependent, if applicable, in accordance with your policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

- (1) the premium for such Insured and his/her Dependents, if applicable, continues to be paid during the leave; and
- (2) you have approved the Insured's leave in writing and provide a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

- (1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
- (2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue the Insured's coverage and that of any Insured Dependents, if applicable, in accordance with your policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured and his or her Dependents, if applicable, continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

This Policy, while coverage is being continued under this Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While the Insured is on a Family and Medical Leave of Absence for any reason other than his or her own illness or injury, or Military Services Leave of Absence, he or she will be considered Actively at Work. Any changes such as revisions to coverage due to change in class will apply during the leave except that increases in the Benefit Amount, whether automatic or subject to election, will not be effective for an Insured who is not considered Actively at Work until the Insured has returned to Active Work for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in this Policy.

The Insured's coverage and that of any Insured Dependent's, if applicable, will cease under this extension on the earliest of:

- (1) the date this Policy terminates; or
- (2) the end of the period for which premium has been paid for the Insured and Insured Dependent, if applicable; or
- (3) the date such leave should end in accordance with your policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should you choose not to continue the Insured's coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, the Insured's coverage as well as any Dependent coverage, if applicable, will be reinstated in accordance with the Family and Medical Leave of Absence and USERRA.

PREMIUMS

PREMIUM PAYMENT: All premiums are to be paid by you to us, or to an authorized agent, on or before the due date. The premium due dates are stated on the face page of this Policy.

PREMIUM RATE: The premium for this insurance is based on the coverage selected:

- (1) Eligible Person Only
- (2) Eligible Person and Dependent spouse
- (3) Eligible Person and Dependent child(ren)
- (4) Eligible Person and Dependents

We reserve the right to adjust the premium rate on any premium due date:

- (1) after coverage has been in force for twenty-four (24) months; or
- (2) if the coverage is changed by amendment.

We will not change the premium rate more than once in any twelve (12) month period unless the coverage is changed. We will notify you in writing at least thirty-one (31) days before a premium change is made due to (1) above.

GRACE PERIOD: You may pay the premium up to thirty-one (31) days after the date it is due. This Policy stays in force during this time. If the premium is not paid during the grace period, this Policy will be cancelled at the end of the grace period. You will still owe us the premium up to the date this Policy is cancelled.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: If the Insured dies, any death benefit payable and any other accrued benefits will be paid to the beneficiary named in records maintained by you. A beneficiary designation will be effective as of the date the Insured signed it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

The Insured will be the beneficiary of any benefit payable at the death of an Insured Dependent, unless another beneficiary has been named and placed on file as required.

The Insured can change the beneficiary by telling us in writing on our form. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received and approved by us or an authorized Plan Administrator. We cannot attest to the validity of such a change.

If an Insured's beneficiary dies at the same time as the Insured, or within fifteen (15) days after his/her death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise in another provision of this Policy.

If the Insured has not named a beneficiary, or an Insured's named beneficiary is not surviving at the Insured's death, any benefits due shall be paid to the first of the following classes to survive the Insured:

- (1) the Insured's legal spouse;
- (2) the Insured's surviving children (including legally adopted children), in equal shares;
- (3) the Insured's surviving parents, in equal shares;
- (4) the Insured's surviving siblings, in equal shares; or, if none of the above,
- (5) the Insured's estate.

We will not be liable for any payment we have made in good faith.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed \$1,000.

If the Insured has not named a beneficiary or the beneficiary is not surviving at the Insured's death, we may pay up to \$2,500 of the benefit to the person(s) who, in our opinion, has incurred expenses in connection with the Insured's last illness, death or burial. Payment may also be made to the executor or administrator of the Insured's estate, or to any relative of the Insured by blood or marriage.

The balance of the benefit, if any, will be held by us, until an individual or representative:

- (1) is validly named; or
- (2) is appointed to receive the proceeds; and
- (3) can give valid release to us.

With respect to the Facility of Payment provision, the benefit will be held with interest at a rate set by us.

We will not be liable for any payment we have made in good faith.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after the service or event occurs for which claim may be made, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name or Insured Dependent's name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within fifteen (15) days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the claim.

PROOF OF CLAIM: We must be given written proof of claim within ninety (90) days after the date of services or the occurrence of an event, or as soon as soon as reasonably possible thereafter. In any event, proof must be given within one (1) year, unless the claimant is legally incapable of doing so.

Proof of claims must include:

- (1) the nature and date of the claim and reason claim is being made;
- (2) a description of the event and/or services provided; and
- (3) proof that the services or event occurred. Such proof may take the form of a receipt for services or some other official documentation supporting the claim and which is acceptable to us.

Within fifteen (15) days after receiving the first proof of claim, we may send a written acknowledgment. Such acknowledgment may request any missing information or other items we need in order to adjudicate the Insured's or Insured Dependent's claim. Such information or items we may request may include, but are not limited to:

- (1) copies of x-rays or any other diagnostic tests performed;
- (2) copies of medical records or charts; or
- (3) any other information we may reasonably require.

TIME PAYMENT OF CLAIMS: When we receive satisfactory written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid accordingly.

Simple interest will accrue on claims that are not processed promptly. The rate will be as required by Indiana law.

Under a clean claim, interest will accrue from:

- (1) the forty-sixth (46th) day after we receive the first proof of claim in writing; or
- (2) the thirty-first (31st) day after we receive the first proof of claim by electronic means.

A claim is considered "clean" when the first proof of claim is complete; no part of the claim is contested; and no other defect prevents prompt payment. A claim will also be considered "clean" when we fail to promptly request more information or to resolve it, within forty-five (45) days after receiving a written claim or thirty (30) days after receiving an electronic claim.

Under a defective claim, interest will accrue from:

- (1) the forty-sixth (46th) day after we receive enough proof to confirm liability, if the claim is filed in writing and we request more information within forty-five (45) days; or
- (2) the thirty-first (31st) day after we receive enough proof to confirm liability, if the claim is filed by electronic means and we request more information within thirty (30) days.

A claim is considered "defective" when the first proof of claim is incomplete; any part of the claim is contested; or some other defect prevents prompt payment.

PAYMENT OF CLAIMS: If an Insured dies, we will pay any death benefit and any other accrued benefits in accordance with the Beneficiary and Facility of Payment provisions. All other benefits will be paid to the Insured.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on

all parties.

PHYSICAL EXAMINATION AND AUTOPSY: At our own expense, we have the right to have the Insured or Insured Dependent examined as often as reasonably necessary when a claim is pending. We can also have an autopsy performed unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on this Policy within sixty (60) days after written proof of claim has been given as required by this Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina, six (6) years) from the time written proof of claim is required to be submitted.

PORTABILITY

The Insured may continue the Group Accident insurance coverage under this Policy and that of his/her Insured Dependents if coverage would otherwise terminate because he/she ceases to be an Eligible Person, for reasons other than the termination of this Policy or the Insured's retirement provided he/she:

- (1) notifies us in writing within thirty-one (31) days from the date he/she ceases to be eligible; and
- (2) remits the necessary premiums when due; and
- (3) has been covered for twelve (12) months under this Policy and/or the prior group accident insurance policy.

The Benefit Amount available under the Portability provision will be the current Benefit Amount the Insured and Insured Dependents are insured for under this Policy on the last day the Insured was Actively at Work.

The premium charged to continue coverage will be based on the prevailing rate charged to Insureds who choose to continue coverage under the Portability provision. Such premium will be billed directly to the Insured on a quarterly basis.

If an Insured's and Insured Dependents' Group Accident coverage under this Policy includes the Wellness Benefit and Accidental Death and Dismemberment Benefit, then such benefits may be continued under this Policy.

Insurance coverage continued under this provision for the Insured or his/her Insured Dependents will terminate on the first of the following to occur:

- (1) the end of the period for which premium has been paid; or
- (2) the date the Insured reaches age seventy (70); or
- (3) at any time coverage would normally terminate according to the terms of this Policy had the Insured continued to be an Eligible Person.

In addition, coverage will reduce at any time it would normally reduce according to the terms of this Policy had the Insured and Insured Dependent spouse continued to be eligible.

If this Policy terminates subsequent to the Insured's election to continue his/her coverage and that of his/her Insured Dependents, in accordance with the Portability provision, such coverage will be continued in accordance with the provisions of the Insured's certificate.

EXCLUSIONS

This Policy does not cover any loss:

- (1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or
- (2) caused by committing or attempting to commit suicide, while sane or insane, or intentionally self-inflicted injuries; or
- (3) caused by or resulting from war or any act of war, declared or undeclared; or
- (4) caused by or resulting from riding in, getting into or out of any aircraft, unless:
 - (a) the Insured or Insured Dependent is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
 - (b) the aircraft is not owned, leased or operated by or on behalf of you, the Insured or Insured Dependents, or any other employer of the Insured or Insured Dependents, unless a specific written agreement has been obtained from us; or
- (5) sustained during the Insured's or Insured Dependent's commission or attempted commission of an assault or felony; or
- (6) to which the Insured's or Insured Dependent's acute or chronic alcoholic intoxication is a contributing factor; or
- (7) to which the Insured's or Insured Dependent's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.

The Indiana 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 significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Indiana Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Indiana Life and Health Insurance Guaranty Association when electing an insurer.

You may contact the Indiana Life and Health Insurance Guaranty Association as follows:

Indiana Life and Health Guaranty Association
251 E. Ohio Street, Suite 1070
Indianapolis, IN 46204
(317) 636-8204
www.inlifega.org

You may contact the Indiana Department of Insurance as follows:

Indiana Department of Insurance
311 W. Washington Street
Indianapolis, IN 46204
(317) 232-2385
www.in.gov/idoi

NOTICE TO POLICYHOLDERS/INSUREDS

Questions regarding your policy or coverage should be directed to:

**Reliance Standard Life Insurance Company
2001 Market Street, Suite 1500
Philadelphia, PA 19103-7090
(267) 256-3500**

Toll-free telephone number: 1-800-644-1103

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or e-mail:

**State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787**

Consumer Hotline: 1-800-622-4461; (317)-232-2395

Complaints can be filed electronically at www.in.gov/idoi.