THE UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724
1-800-123-4567

BLANKET ACCIDENT ONLY POLICY

POLICYHOLDER:	**Competitive Advantage Program, LLC (CAP)**
POLICY NUMBER:	US2144817
POLICY EFFECTIVE DATE:	January 27, 2025
POLICY EXPIRATION DATE:	January 27, 2026

This Policy is issued in the state of Indiana and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain persons and pay benefits.

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

10 DAY RIGHT TO RETURN THIS POLICY

If for any reason, you are not satisfied with this Policy, you may return it to us within 10 days after receiving it. Upon its return, we will refund any premium paid and this Policy 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 POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.

THIS POLICY IS NOT RENEWABLE.

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

Marc J. Adee
Chairman and CEO

Michael P. McTigue
Secretary

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

SCHEDULE OF BENEFITS

BENEFIT PERIOD:	**104 weeks from the date of the Covered Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary.**
CLASS OF ELIGIBLE PERSONS:	**Class 1: All dues paying CAP Member Participants in good standing (and on file at SIS before the injury occurs) that are in a restricted area of an automobile race track during an event/activity**

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum:	**$10,000**
Time Period for Loss:	**365 days**

ACCIDENT MEDICAL EXPENSE BENEFIT

Maximum for all Accident Medical	**$500,000**
Disappearing Deductible:	**$15,000**

The Disappearing deductible must be satisfied before this plan will pay benefits. Amounts paid by other carriers will be used to satisfy the deductible under this plan. With a Disappearing Deductible, any amounts paid by other valid and collectible insurance toward the satisfaction of bills generated as a result of a covered accident will count toward satisfying the deductible. If the Covered Person's primary insurance makes any payment on an eligible expense, it counts toward the deductible, and amounts paid in excess of and applied to the deductible will cause the deductible to disappear or be reduced.

ACCIDENT MEDICAL EXPENSE BENEFITS

Hospital Room & Board Daily Maximum Benefit:	**100% of the Semi-Private Room Rate**
Intensive Care /Cardiac Care Room & Board:	**100% of Usual Reasonable & Customary Charges, URC**
Hospital Miscellaneous Benefit:	**100% of URC**
Pre-Admission Testing Benefit:	**100% of URC**
In-Patient Surgical Benefits:	
Primary Surgeons Maximum Benefit Amount:	**100% of URC**

Assistant Surgeon Benefit:	**100% of URC**
Out-Patient Surgery Benefits:	
Outpatient Primary Surgeons Maximum Benefit Amount:	**100% of URC**
Outpatient Assistant Surgeon Maximum Benefit:	**100% of URC**
Outpatient Surgical Facility Maximum Benefit per	**100% of URC**
Emergency Room Benefit	**100% of URC**
Anesthesia Benefit:	**100% of URC**
Physician's Visits	
In-Hospital Maximum Benefit:	**100% of URC**
Physician's Visits	
Office Visits (Out-of-Hospital) Maximum Benefit:	**100% of URC**
X-Ray Benefit	**100% of URC**
Laboratory Benefit	**100% of URC**
Nursing Benefit Amount:	**100% of URC**
Outpatient Physiotherapy Benefit	**100% of URC**
Ambulance Benefit Amount:	**100% of URC**
Dental Treatment For Injury Only Benefit Amount:	**100% of URC**
OUT-PATIENT PRESCRIPTION DRUG BENEFIT	
Benefit payable per prescription	**100% of URC**
DURABLE MEDICAL EQUIPMENT BENEFIT	**up to $500,000**

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Policy. 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.

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 Policy.

Disappearing Deductible means a dollar amount of Covered Expenses the Insured Covered Person must pay before We pay any benefits. The Deductible may be satisfied by Other Valid and Collectible Insurance or Plan. The Disappearing Deductible is shown on the Schedule of Benefits.

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 Policy is in force.

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

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:
1. Group or blanket insurance, whether on an insured or self-funded basis;
2. Hospital or medical service organizations on a group basis;
3. Health Maintenance Organizations on a group basis.
4. Group labor management plans;
5. Employee benefit organization plan;
6. Professional association plans on a group basis; or
7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

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 or this Certificate .

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.).

Other Valid and Collectible Insurance means any reimbursement for or recovery of any element of Covered Expenses incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of Accident, disability or health insurance.
2. Any arrangement of benefits for members of a group, whether Insured or uninsured.
3. Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations.
4. Any amount payable for Hospital, medical or other health services for Accidental bodily Injury arising out of a motor vehicle Accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits

mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or injuries or diseases related to the Covered Person's job to the extent that he actually received benefits under a Worker's Compensation Law. If the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement.
6. Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after he or she becomes disabled while Insured hereunder.
7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

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.

Supervised or Sponsored Activity means a Policyholder or School authorized function:
1. In which the Covered Person participates;
2. Which is organized by or under its auspices;

which is within the scope of customary activities for such entity and is shown on the Schedule of Benefits.

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 Policy are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits/Application . This includes anyone who may become eligible while this Policy 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 Policy, provided proper premium payment is made, on the latest of:
1. The Effective Date of the Policy; or
2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/ Enrollment Form.

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 this 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.

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 this 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 this 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 this 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 this 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 Policy 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 Policy; and
3. Is within the scope of the risks set forth in the **DESCRIPTION OF HAZARDS** provisions.

Full Excess Medical Expense:
If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, we will pay the Eligible Expenses incurred, subject to the Deductible Amount (if any), that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury:

1. While the person is insured under this Policy; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Policy is shown on the SCHEDULE OF BENEFITS: and

1. Subject to the specific maximums shown on the SCHEDULE OF BENEFITS; and
2. Subject to compliance with the requirement, set forth in the Limitations section of this Policy.

DESCRIPTION OF HAZARDS

HAZARD: SPECIFIC ACTIVITY

We will pay the benefits described in this Policy, to the extent this Policy does not provide coverage, for a covered loss by participating in an oval racing, road course and/or dragstrip event, which occurs in the restricted area of the track.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH & DISMEMBERMENT
If, within 1 year from the date of an Accident covered by this Policy, 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	Percentage of Principal Sum
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing (both ears)	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of speech means total, permanent and irrecoverable loss of audible communication.

Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT MEDICAL and DENTAL EXPENSE BENEFITS

We will pay Accident Medical and Dental 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. **Intensive Care/ Cardiac Care Room and Board** - charges for each day of Intensive Care/ Cardiac Care Unit confinement, up to the maximum benefit amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.

3. **Hospital Miscellaneous** – services, supplies and charges during a Hospital Stay, up to the maximum benefit amount shown in the Schedule of Benefits for the Hospital Miscellaneous Benefit. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

4. **Pre-Admission Testing Benefit** – charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing)

5. **In-Patient Surgical Benefits** - charges for:

    a. A Physician, for primary performance of a surgical procedure, up to the maximum benefit amount shown in the Schedule of Benefits per procedure. 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.

    b. A Physician, for: assistant surgeon duties up to the maximum benefit shown in the Schedule of Benefits for an Assistant Surgeon

6. **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.

7. **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.

8. **Anesthesia Benefit** – Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis, up to the maximum benefit amount shown in the Schedule of Benefits for the Anesthesia benefit.

9. **Physician's Visits** - charges by a Physician for other than pre- or post-operative care:

   a. For in-Hospital visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

   b. For office visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Office Visits.

   Total visits per Injury will not exceed the combined maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

10. **X-Ray Benefit -** We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires x -ray examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

11. **Laboratory Benefit-** We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires laboratory examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

12. **Nursing Benefit**– Outpatient Charges for nursing services by a registered nurse or licensed professional nurse, up to the maximum benefit amount shown on the Schedule of Benefits for the Nursing benefit.

13. **Physiotherapy -** Charges for physiotherapy:

   a. As an outpatient, up to the maximum benefit amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

   Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic , adjustments , manipulation , acupuncture , massage or any form of physical therapy.

   Total treatment per Injury will not exceed the maximum benefit amounts for Physiotherapy shown in the Schedule of Benefits*.*

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

15. **Dental Treatment for Injury Only** - Charges for dental treatment including dental x-rays for the repair and treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the maximum benefit amount shown in the Schedule of Benefits for the Dental Treatment benefit.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses- shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:
1. Under Federal law may only be dispensed by written prescription; and
2. Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the out-patient use by the Covered Person:
1. On or after the Covered Person's Effective Date; and
2. By a licensed pharmacy provider.

Benefits are payable up to the maximum benefit amount shown on the Schedule of Benefits.

DURABLE MEDICAL EQUIPMENT BENEFIT

We will pay the benefit shown in the Schedule of Benefits if, by reason of Injury, a Covered Person requires the use of Durable Medical Equipment.

Durable Medical Equipment means medical equipment that:
1. is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. can withstand long-term repeated use without replacement;
3. is not useful in the absence of the Covered Injury and
4. can be used in the home without medical supervision; and
5. the purpose of the equipment is not to help the Covered Person participate in sports activity.

EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under this Policy 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. 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.
7. Disease or disorder of the body or mind.
8. Mental or nervous disorders.
9. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person’s job.
10. 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.

11. Intoxication or being under the influence of any drug or narcotic.
12. 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.
13. Driving under the influence of a controlled substance unless administered on the advice of a Physician.
14. Driving while Intoxicated. Intoxicated will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.
15. 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.
16. Conditions that are not caused by a Covered Accident.
17. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
18. Any treatment, service or supply not specifically covered by this Policy.
19. Loss resulting from participation in any activity not specifically covered by this Policy.
20. Charges which Are in excess of Usual, Reasonable and Customary charges.
21. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
22. Regular health check ups.
23. Services or treatment rendered by a Physician, Nurse, or any other person who is employed or retained by the Policyholder.
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. Treatment of a hernia whether or not caused by a Covered Accident.
29. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
30. Damage or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
31. 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 Policy, and rendered within 6 months of the Accident. .
32. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore.
33. 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.
34. 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. While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
    e. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    f. an ultralight hang-gliding, parachuting, or bungi-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.
35. 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

36. The repair or replacement of existing artificial limbs, orthopedic braces or orthotic devises.
37. Rest cures or custodial care.
38. Elective or Cosmetic surgery, except for reconstructive surgery on an injured part of the body.

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 Policy. 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 Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

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 Policy, 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.

The Covered Person, his beneficiary, or representative, shall have the right to make written request for a copy of the application and We shall within 15 days after receipt of such request, deliver or mail to the person making such request, a copy of the application. If such copy is not delivered or mailed, We shall be precluded from introducing such application as evidence in any action based upon or involving any statements made within such application.

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

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

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

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

REPORTING REQUIREMENTS:
The Policyholder or its authorized agent must report to us, by the premium due date:
1. The names of all persons insured on the Effective Date of this Policy;
2. The names of all persons who are insured after the Effective Date of this Policy;
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 Policy in conflict, on the Effective Date of this Policy, 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 15 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 Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

In case of claim for any other 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 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, or We shall pay or deny each clean claim or notify the Covered Person of any deficiencies within 30 days if the claim is filed electronically or within 45 days if the claim is filed via paper.

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.

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 Policy, if the third party's liability is satisfied in an amount less than the benefits payable under this Policy, 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.

RECOVERY OF BENEFITS:
We reserve the right to recover from a Covered Person any benefits we have paid to him for injuries:
1. Received in a covered Accident; and
2. Which are covered under:
    a. workers' compensation or similar statutory remedies available under law; or
    b. Any employer's liability Insurance.

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

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

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

GRIEVANCE PROCEDURES

You, or your authorized representative, have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse 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"** means any dissatisfaction expressed by or on behalf of a covered individual regarding:

1. A determination that a service or proposed service is not appropriate or medically necessary;
2. A determination that a service or proposed service is experimental or investigational;
3. The availability of participating providers;

4. The handling or payment of claims for health care services; or
5. Matters pertaining to the contractual relationship between:
    a. A covered individual and an insurer; or
    b. A group policyholder and an insurer;

And for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

INTERNAL GRIEVANCE PROCEDURE

You may file a grievance orally or in writing. A grievance is considered to be filed on the first date it is received, either by telephone or in writing.

If You wish to file a grievance orally, the toll free telephone number to call is (xxx)-xxx-xxxx.

Upon receipt of a Grievance, United States Fire shall give oral or written acknowledgment to you within five (5) business days.

If within five (5) working days of the Filing Date United States Fire is unable to find sufficient information to complete the Internal Grievance Process, United States Fire shall notify you or your Health Care Provider that they cannot proceed with reviewing the Grievance unless additional information is provided. You may obtain assistance from United States Fire in gathering the necessary information.

Upon completion of United States Fire's investigation, United States Fire shall notify you in writing of the final determination, and the reason for such determination after you or the health care provider acting on your behalf have received oral communication of the decision. Final determination shall be rendered within twenty (20) business days from the Filing Date. If United States Fire is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond its control, United States Fire shall:

1. before the twentieth business day, notify the covered individual in writing of the reason for the delay and;
2. Issue a written decision regarding the grievance within an additional ten (10) business days.

Within five (5) working days after the final decision has been made, including retrospective denials, United States Fire shall provide a notice of the decision to you stating:

(1) A statement of the decision reached;
(2) The criteria and standards on which the decision was based;
(3) The contact person responsible for the Internal Grievance Process and the department address and telephone number;
(4) The Commissioner's address, telephone number, and facsimile number; and
(5) That you have a right to file an appeal

APPEALS

The Appeals process is available if the covered individual is not satisfied with the outcome of the Review that results in an Adverse Determination. The covered individual will be notified within five (5) business days after the appeal is filed. The covered individual has the opportunity to appear in person, or if unable to appear in person, otherwise appropriately communicate with the panel.

A panel of one (1) or more qualified individuals will be comprised to resolve an appeal. The panel will include one (1) or more individuals who:

(1) have knowledge of the medical condition, procedure, or treatment at issue;
(2) Are licensed in the same profession and have similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;

(3) were not previously involved in any matter giving rise to the Second Level Review;
(4) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the heath care procedure, treatment or service giving rise to the grievance.

An appeal of a grievance decision must be resolved:

(1) as expeditiously as possible, reflecting the clinical urgency of the situation; and
(2) not later than forty-five (45) days after the appeal is filed.

The decision must be notified to the covered individual in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing the investigation. The appeal resolution notice must include the following:

(1) A statement of the decision reached;
(2) A statement of the reasons, policies, and procedures that are the basis of the decision.
(3) Notice of the covered individual's right to further remedies allowed by law, including the right to external grievance review by an independent review organization.
(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

EXTERNAL GRIEVANCE PROCEDURE

An external grievance procedure allows a covered individual or a covered individual's representative to file a written request with United States Fire for an external grievance review of the appeal resolution. This written request must occur not more than forty-five (45) days after the covered individual is notified of the resolution. A covered individual may file not more than one (1) external grievance of an appeal resolution.

A standard external grievance review for a grievance will be provided; or

An expedited external grievance review will be provided for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's
(1) Life or health; or
(2) Ability to reach and maintain maximum function.

When a written requested for an external grievance review is filed, United States Fire shall:

(1) Select a different independent review organization for each external grievance filed from the list of independent review organizations that are certified by the department; and
(2) Rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

The Independent review organization and the medical review professional conducting the external review may not have a material professional, familial, or other affiliation with any of the following:

(1) United States Fire Insurance Company
(2) Any officer, director, or management employee of United States Fire Insurance Company
(3) The health care provider or the health care provider's medical group that is proposing the service;
(4) The facility at which the service would be provided
(5) The development or manufacture of the principal drug, devise, procedure, or other therapy that is proposed for use by the treating health care provider
(6) The covered individual requesting the external grievance review.

The Independent review organization shall:

(1) for an expedited external grievance filed, within seventy-two (72) hours after the external grievance is filed; or
(2) for a standard appeal filed, within fifteen (15) business days after the appeal is filed;

make a determination to uphold or reverse the appeal resolution based on information gathered from the covered individual or the covered individual's designee; the United States Fire Insurance Company, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

The Independent review organization shall notify United States Fire Insurance Company and the covered individual of the determination made:

(1) for an expedited external grievance filed, within seventy-two (72) hours after making the determination; and
(2) for a standard external grievance filed, within seventy-two (72) hours after making the determination.

If at any time during an external review, the covered individual submits information to United States Fire that is relevant to the resolution of the covered individuals appeal of a grievance decision, and that was not considered by United States Fire:

(1) United States Fire Insurance Company may reconsider the resolution; and
(2) If United States Fire chooses to reconsider, the independent review organization shall cease the external review process until the reconsideration is completed.

When reconsidering the resolution of an appeal of a grievance decision due to the submission of additional information, the United States Fire insurance company shall notify the covered individual of the decision:

(1) Within seventy-two (72) hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the covered individual's
   a. life or health; or
   b. ability to reach and maintain maximum function; or

(2) Within fifteen (15) days after the information is submitted for a reconsideration not described in section one(1).

If the decision reached is adverse to the covered individual, the covered individual may request that the independent review organization resume the external review. If the United States Fire Insurance Company chooses not to reconsider the resolution after additional information is submitted, the submitted information shall be forwarded to the independent review organization not more than two (2) business days after the receipt of the information.

Questions regarding your policy or coverage should be directed to:

United States Fire Insurance Company
Administrative Office: 5 Christopher Way Eatontown, NJ 07724
Contact number for the applicable Producer/TPA

If you (a) need 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 email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, suite 300
Indianapolis, Indiana 46204

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

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