NEW JERSEY

Gap ER Plan

Member Driven **Value.**

Certificates of Insurance

Download Claim Forms:
ubamembers.com/claimforms.html

DAILY HOSPITAL CONFINEMENT BENEFIT

EMERGENCY ROOM VISIT BENEFIT

NON-INSURANCE SERVICES

These Certificates of Insurance are for the Gap ER Plan. You can call your personal member concierge at 866.438.4274 for any questions regarding your certificates.

Group Hospital Fixed Indemnity Insurance is underwritten by United States Fire Insurance Company
Non-Insurance Services are provided by United Business Association

ATTENTION PLEASE

READ CAREFULLY FOR ALL LIMITATIONS, EXCLUSIONS, AGE LIMITS, DEFINITIONS AND SCHEDULE OF BENEFITS.

GapER_CertificatesofInsurance_v10.20 [ah-2498]
United Business Association
409 W Vickery Blvd, Fort Worth, TX 76104 | 866.438.4274 | ubamembers.com

Member Driven Value.

PGS 03-28

Group Hospital Fixed Indemnity Insurance Certificate of Insurance

ASSOCIATION BENEFITS PROVIDED BY:

UBA

GROUP HOSPITAL FIXED INDEMNITY INSURANCE COVERAGE UNDERWRITTEN BY:

United States Fire Insurance Company

CRUM & FORSTER

A FAIRFAX COMPANY

BILLING, FULFILLMENT, & CUSTOMER SERVICE PROVIDED BY:

HealthyAmerica

UNITED STATES FIRE INSURANCE COMPANY

Wilmington, Delaware
Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

GROUP BENEFITS – HOSPITAL FIXED INDEMNITY CERTIFICATE OF INSURANCE

POLICYHOLDER:	United Business Association
POLICY NUMBER:	US1068698
POLICY EFFECTIVE DATE:	March 15, 2018
CERTIFICATEHOLDER:	Please see the Enrollment Form
CERTIFICATE EFFECTIVE DATE:	Please see the certification section of the Enrollment Form
CERTIFICATE EXPIRATION DATE:	Until Cancelled

This Certificate is evidence of the Covered Person's insurance under the Policy that We have issued to the Policyholder named above. The provisions of the Policy are summarized in this Certificate. This Certificate replaces any other Certificate We may have previously provided under the Policy.

The Policy is issued in the state of Texas
The Policy is governed by the laws of the state where it was delivered.

The Policy is a legal contract between the Policyholder and United States Fire Insurance Company (herein referenced as "the Company"). The Policy alone is the only contract under which payment will be made. The Policy may be inspected at the office of the Policyholder.

THIS IS A CERTIFICATE OF INSURANCE FOR A LIMITED FIXED INDEMNITY POLICY.
IT PAYS BENEFITS REGARDLESS OF ANY OTHER INSURANCE.
THE POLICY IS NOT A MAJOR MEDICAL OR
COMPREHENSIVE MEDICAL HEALTHCARE POLICY.
PLEASE READ THIS CERTIFICATE CAREFULLY.

THE POLICY IS OPTIONALLY RENEWABLE.
Non-Participating Insurance

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

Marc J. Adee
Chairman and CEO

James Kraus
Secretary

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SCHEDULE OF BENEFITS

POLICYHOLDER: United Business Association
POLICY EFFECTIVE DATE: March 15, 2018
POLICY NUMBER: US1068698
PREMIUM DUE DATE: Per Option Chosen on the Enrollment form
CERTIFICATEHOLDER: Please see the Enrollment Form
CERTIFICATE EFFECTIVE DATE: Please see the certification section of the Enrollment Form
CERTIFICATE EXPIRATION DATE: Until Cancelled

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class. Also, a person may not be covered as a Dependent and a Covered Person at the same time.

Class 1 All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP AME, GAP MAX, Super GAP, & the GAP ER plan options and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

SCHEDULE OF BENEFITS

LIMITED FIXED INDEMNITY BENEFITS

COVERED BENEFIT FOR EACH COVERED PERSON:

Plan	Daily Benefit Amount
Daily Hospital Confinement Benefit	$40 per day for days 1 - 35 for a Hospital Confinement occurring in a Policy Period

DEFINITIONS

Please note certain words used in this document have specific meanings. The male pronoun includes the female whenever used. Additional terms may be defined within the provision to which they apply.

The capitalized terms used herein are defined as follows:

"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.

"Certificate Holder" means a person to whom an insurance certificate has been issued evidencing coverage under the Policy.

"Child" means the Insured Person's or Civil Union Partner's: natural Child, adopted Child (or Child placed in the Insured Person's or Civil Union Partner's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Insured Person or Civil Union Partner has legal guardianship (proof will be required). A Child must reside with the Insured Person or Civil Union Partner in a parent-Child relationship and be eligible to be claimed as an exemption on the Insured Person's or Civil Union Partner's federal income tax return. NOTE: In the event the Insured Person or Civil Union Partner shares physical custody of the Child with another parent, the requirement that the Child reside with the Insured Person or Civil Union Partner will be waived.

"Civil Union Partner" means the parties to a civil union who are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded to spouses. Throughout the Policy, a party to a civil union shall be included in any definition or use of the terms such as spouse, family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used.

"Company" means United States Fire Insurance Company. Also hereinafter referred to as We, Us and Our.

"Complications of Pregnancy" means a condition which:

- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include:

- False labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning sickness;
- Preeclampsia; and
- Similar conditions associated with the management of a difficult pregnancy, but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in

immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

"Covered Accident" means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss for which benefits are payable.

"Covered Loss or Covered Losses" means an accidental death, dismemberment or other Injury or Sickness covered under the Policy and indicated on the Schedule of Benefits.

"Covered Person" means an Insured Person and Dependent eligible for coverage as identified in the Enrollment/Application who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, for whom proper premium payment has been made when due, and who is therefore insured under the Policy.

"Dependent" means the:
1) Insured Person's lawful spouse, if not legally separated or divorced, or Civil Union Partner.
2) Insured Person's or Civil Union Partner's unmarried Children under age 26.

The age limitations will not apply to an unmarried Child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

"Enrollment Period" means the period agreed upon by the Policyholder and Us when an Eligible Person may enroll for coverage or an Insured may change benefit elections under the Policy.

"He", "His" and "Him" includes "she", "her" and "hers."

"Hospital" means an institution licensed, accredited or certified by the State that:
1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
4) Has a staff of one or more licensed Physicians available at all times;
5) Provides organized facilities for diagnosis, treatment and surgery, either
   a) on its premises; or
   b) in facilities available to it, on a pre-arranged basis;
6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.
We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:
1) the Joint Commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of

such a facility and is a Covered Benefit under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

"Hospital Stay or Hospital Confinement" 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.

"Immediate Family Member" means a Covered Person's spouse, Civil Union Partner, parent, Child(ren) (includes legally adopted or step Child(ren), brother, sister, grandchild(ren), or in-laws.

"Injury" means bodily Injury caused by the direct result of an Accident occurring after the effective date of a Covered Person's coverage under the Policy, while the Policy is in force as to the person whose Injury is the basis of the claim which results, directly and independently of disease, bodily infirmity and all other causes, in a Covered Loss. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

"Insured Person" means a member of the Policyholder who is eligible, who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person under the Policy. A Dependent covered under the Policy is not an Insured Person.

"Life Status Change" means an event recognized by the Policyholder and Us that qualifies the Insured Person to make changes in coverage at any time other than an Enrollment Period. The following events are all considered Life Status Changes:

1) marriage;
2) divorce, annulment or legal separation from a Spouse or Civil Union Partner;
3) birth or adoption of a child;
4) change in a Dependent child's eligibility;
5) death of a Spouse or Civil Union Partner;
6) a change in the benefit plan or employment status of the Insured Person's Spouse or Civil Union Partner that affects either person's eligibility for benefits.

"Medical Emergency" means a Sickness or Injury for which the Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- Serious disfigurement of the Covered Person;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Treatment for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions.

"Medically Necessary" or "Medical Necessity" means a treatment, drug, device, service, procedure or supply that is:

1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;
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.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Covered Person, the Covered Person's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

"Mental Illness or Nervous Disorder" means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

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

"Optionally Renewable" means renewal is at the option of United States Fire Insurance Company.

"Physician" means a person who is a qualified practitioner of medicine. As such, He or She must be acting within the scope of his/her license 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 or Civil Union Partner, son, daughter, father, mother, brother or sister or other relative."

"Policy Period" means, initially, the period of time from the Effective Date of the Policy until the first Policy Anniversary Date, and thereafter each subsequent 12 consecutive months provided coverage remains in force.

"Policyholder" means the entity shown as the Policyholder in the Schedule of Benefits.

"Pre-existing Condition" means a disease or physical condition for which medical advice or treatment was recommended or received by the Covered Person during the 12 months prior to the Covered Person's Effective Date of coverage.

"Sickness" means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person receives medical treatment while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"Spouse" means lawful spouse, if not legally separated or divorced, or Civil Partner.

"Substance Abuse" means the use of any drug or substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

"We, Our, Us" means United States Fire Insurance Company underwriting this insurance or its authorized agent.

"You, Your, Yours, He or She" means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

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

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

An Insured Person's Dependent(s), as applicable, are eligible on the latest of the date:
1) the Insured Person is eligible, if the Insured Person has Dependents on that date; or
2) the date the person becomes a Dependent; or

If the Insured Person is in a Class of Eligible Persons and is also eligible as a Dependent, He or She may be Covered only once under the Policy. In no event will a Dependent be eligible if the Covered Person is not eligible.

EFFECTIVE DATE 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:
An Eligible Person will become insured under the 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 Eligibility Waiting Period, according to the referenced date shown in the Application/Enrollment Form.

Newborn Children Coverage: We will provide coverage for a newborn Child from the moment of birth. The Insured Person must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate at the expiration of the initial 31 day period.

Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by the Insured Person or Civil Union Partner prior to the birth of the Child, whether or not such agreement is enforceable. The Insured Person must give Us notice within 31 days of the birth of the adopted Child. If notice is not given within 31 days, coverage for the newborn adopted Child will terminate at the expiration of the initial 31 day period.

Newborn Child Exception: This section does not apply to a newborn Child at that Child's birth if the Child is born to a Covered Person while insured as a Dependent Child under the Policy. Benefits for Newborn Children apply only to a Child born to an Insured Person or their Spouse or Civil Union Partner.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in the Insured Person's or Civil Union Partner's home. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate at the expiration of the initial 31 day period.

Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child, will be covered on the same basis as an adopted Child.

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 Expiration Date shown in the Policy; or
2) The premium due date if premiums are not paid when due, subject to any Grace Period.

Failure by the Policyholder to pay all required premiums due by the last day of the Grace Period shall be deemed notice by the Policyholder to the Company to terminate the Policy upon the expiration of such Grace Period.

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

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

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

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

Dependent's Termination Date
A Dependent's coverage under the Policy ends on the earliest of:
1) The date the Policy terminates; or
2) The date the Insured Person's coverage ends; or
3) The date the Dependent is no longer a Dependent; or
4) The last day of the period for which premiums have been paid.

DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under the Policy.

Daily Hospital Confinement Benefit

We will pay the Daily Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined as an inpatient and all of the following conditions are met:

1. the Hospital stay is Medically Necessary and the direct result, from no other causes, of Injuries or illness sustained in a Covered Accident or Sickness; and
2. Confinement is at the direction and under the care of a Physician; and
3. While the coverage is in effect.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit for this benefit is payable; or
4. the date insurance under the Policy ends.

EXCLUSIONS

The 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:

1. Suicide, attempted suicide or intentional self-inflicted Injury while sane or insane.
2. while the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
3. Active participation in a riot or insurrection;
4. Treatment for Mental Illness or Nervous Disorders, except as specifically provided in the Policy.
5. Treatment for Substance Abuse, except as specifically provided in the Policy.
6. Any loss sustained or contracted in consequence of the Covered Person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a Physician;
7. Any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony, or to which a contributing cause was the Covered Person's engagement in an illegal occupation;
8. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family Member of the Covered Person.
9. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
10. Participation in any motorized race or speed contest.
11. Aggravation or re-injury of a prior Injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician.
12. Injury to a Covered Person resulting from that Covered Person's willful violation of the Policyholder's rules or regulations. Willful violation includes, but is not limited to: a) working without protective clothing, helmets, gloves, etc., required by the Policyholder's rules or regulations; or b) participating in any activity that is in violation of the Policyholder's rules or regulations.
13. pregnancy, except Complications of Pregnancy or childbirth unless conception occurred while coverage was in force under the Policy.
14. Elective Abortion, including complications. "Elective Abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
15. Experimental or Investigational drugs, services, supplies or procedure that is Experimental or Investigational at the time the procedure is done. For the purposes of this exclusion, "Experimental or Investigational" means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The procedure will also be considered Experimental or Investigational if the Covered Person is required to sign a consent form that indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, that is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental or Investigational. A drug, device or biological product is considered Experimental or Investigational if it does not have FDA approval or approval under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption.
16. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
17. Treatment or services provided by a private duty nurse, unless provided for in the Policy.
18. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
19. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in the Policy.
20. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or

occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in the Policy.

21. Treatment for blood or blood plasma;
22. Routine vision care.
23. 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;
24. Travel in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; snow mobile; or riding in a rodeo according to the Policy provisions; or any off-road motorized vehicle not requiring licensing as a motor vehicle;
25. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    i. While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    ii. While being used for any test or experimental purpose; or
    iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
    iv. 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.
    v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    vi. An ultra light, hang-gliding, parachuting or bungi-cord jumping;

    Except as a fare paying passenger on a regularly scheduled commercial airline.
26. Rest cures or custodial care;
27. Prescription Drugs unless specifically provided for under the Policy.
28. Elective or cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
29. Physiotherapy services.
30. (i) as a result of war or an act of war, if the Injury occurs while serving in the military, naval or air forces of any country, combination of countries or international organization; and (ii) as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the Injury occurs while serving in such forces and are outside the home area;
31. (i) as a result of war or an act of war while serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and (ii) as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the Injury occurs while serving in such unit and are outside the home area;

Pre-existing Conditions Limitation

Pre-existing Conditions will not be covered for a period of the first 12 months after the Covered Person’s Effective Date of coverage (applies to Hospital and Surgery benefits only).

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of claim 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 authorized licensed agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:
1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
2) it is further shown that notice was given as soon as possible.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If the person making claim does not receive such claim forms before the expiration of 15 days after We receive notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proof of Loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS:

Written proof of loss must be furnished to Us in the case of a claim for Covered Loss for which the 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 Covered Loss, proof must be furnished within 90 days after the date of such loss.

If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:
1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and
2) it is further shown that notice was given as soon as reasonably possible.

TIME OF PAYMENT OF CLAIMS:

Benefits due under the Policy for a Covered Loss, other than a loss for which the Policy provides installments, will be paid immediately upon receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for a Covered Loss for which the 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.

PAYMENT OF CLAIMS:

All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

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.

DESIGNATION OR CHANGE OF BENEFICIARY:

Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

1) Beneficiaries designated in writing by the Covered Person for the Policy on file with the Policyholder, if any, otherwise;
2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
3) In equal shares to the members of the first surviving class of those that follow, if any:
    a) a Covered Person's lawful spouse, if not legally separated or divorced, or Civil Union Partner;
    b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
    c) a Covered Person's parents, whether natural, step or adoptive; or
    d) a Covered person's Sisters or Brothers, otherwise.
4) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Covered Person's estate.

PHYSICAL EXAMINATION AND AUTOPSY:

We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy. Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.

RECOVERY OF OVERPAYMENT:

If benefits are overpaid or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods.

1) A request for lump sum payment of the amount overpaid or paid in error; or
2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

LEGAL ACTIONS:

All Policy terms will be interpreted under the laws of the state in which the Policy was issued. No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

RIGHT TO FILE A COMPLAINT

The Policyholder and any Covered Person has the right to file a complaint with the New Jersey Department of Banking and Insurance.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Policy, the Application of the Policyholder (a copy of which is attached to the Policy), endorsements, riders, and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, We may also make it 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 two years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in the Policy will be valid until approved by one of Our executive officers and evidenced by endorsement on the Policy, or by amendment to the Policy, signed by the Policyholder and one of Our executive officers. No agent may change the Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

The Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

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. If either party terminates, written notice must be given to the other party at least 31 days prior to such premium due date.

CONFORMITY WITH STATE STATUTES:

Any provision of the Policy in conflict on its effective date with the laws of the State of Issue indicated on the front page of the Policy is amended to conform to the minimum requirements of such laws.

OTHER COVERAGE WITH US:

At any one time each Covered Person may have only one Certificate issued by Us having coverage similar to that described in the Policy. If we find a Covered Person has more than one such Certificate, coverage will be provided under the plan that has been in force for the longer period of time and any other coverage will be terminated effective immediately. If concurrent coverage is identified, We will refund premiums paid for all other Certificates for concurrent periods of coverage and provide 30 days written notice of termination to the Insured for the most recently acquired coverage.

CLERICAL ERROR:

Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ASSIGNMENT:

No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY:

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Policy.

NON-PARTICIPATING:

The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

WAIVER:

Failure of the Company to strictly enforce its rights under the Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

New Jersey Guaranty Notice

Section 17B:32A-17b of the New Jersey Insurance Code requires all Group Life and Health insurers to provide a summary of the basic provisions of the New Jersey Life and Health Insurance Guaranty Association Act.

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

NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center
7th Floor
Newark, NJ 07102

State of New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

COVERAGE

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the New Jersey Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including new cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits or $500,000 in present value of annuities - again, no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contract holder under any one unallocated annuity contract.

There are not limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

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

United States Fire Insurance Company

GRIEVANCE PROCEDURES

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

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

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

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

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

FORMAL GRIEVANCE PROCEDURE

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

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

First Level Review

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

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.
Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

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

Second Level Review

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

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

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

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

The panel must be comprised of persons who:
(1) were not previously involved in any matter giving rise to the Second Level Review;
(2) are not employees of the Company or Utilization Review Organization; and
(3) do not have a financial interest in the outcome of the review.

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

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

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:
(1) the name(s), title(s) and qualifying credentials of the members of the review panel;
(2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
(3) the review panel's recommendation to the Company and the rationale behind the recommendation;

(4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) the rationale for the Company's decision if it differs from the review panel's recommendation;
(7) a statement that the decision is the Company's final determination in the matter;
(8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

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

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

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

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

PRIVACY NOTICE

United States Fire Insurance Company, The North River Insurance Company and affiliates within Crum & Forster (collectively, "The Company") values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information including nonpublic personal information about our customers and claimants. Nonpublic personal information means information that allows someone to identify or contact you ("Information"). We are committed to protecting such Information and we will comply with all applicable federal and state laws and regulations. This notice describes how we collect, use and share your Information, your rights with respect to insurance products issued by The Company and our legal duties and privacy practices. State laws require that we provide this notice. Please review this Notice and keep a copy of it with your records.

Your privacy is our concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. The Company limits the collection, use, and disclosure of such information to only what is needed to properly produce, underwrite and service its insurance products and/or fulfill legal or regulatory requirements. The Company maintains administrative, technical and physical safeguards that comply with state and federal regulations to protect your Information. We also limit employee access to Information to those with a business reason for knowing such Information and we take measures to enforce employee privacy responsibilities.

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

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

What do we do with the information collected about you?

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

To whom do we disclose information about you?

Access to non-public personal information is limited to those employees, and authorized representatives, attorneys and service providers who specifically need such information to conduct their business responsibilities. In addition, we may disclose all the information that we collect about you to affiliated companies and nonaffiliated third parties (as permitted by law), such as:

- Insurance companies;
- Insurance agencies;
- Loss adjusters;
- Medical providers;
- Third party non-insurance service providers;
- Third party administrators;
- Medical bill review companies;
- Reinsurance companies; and
- Similar service providers.

Crum & Forster requires its service providers to abide by privacy laws in handling non-public personal information obtained through its business relationship with Crum & Forster. Additionally, Crum & Forster may disclose non-public

personal information to third parties as allowed or required by law. For example, Crum & Forster may release your Information to comply with reporting requirements, to comply with a subpoena, warrant, legal process or other order or inquiry of a court, governmental agency or state or federal regulator, or to fulfill C&F's obligations to its insurers and reinsurers We may also share your personal information in order to establish or exercise our rights, to defend against a legal claim, to investigate, prevent, or take action regarding possible illegal activities, suspected fraud, safety of person or property, or a violation of our policies.

If you conclude your relationship with the Company, the Company will continue to safeguard your privacy in accordance with the standards described in this notice. The Company maintains physical, electronic and procedural safeguards to protect non-public personal information.

About Our Websites

We may collect information via technology about how you use our website, including the elements you have interacted with, metadata, and other details about these elements, clicks, change states, and other user actions. This information is used primarily to provide, maintain, protect, and improve our current products and to develop new ones.

We may use cookies on certain pages of our site. Cookies are stored on your computer, not on our site. Most cookies are "session cookies" which means that they are automatically deleted at the end of each session. A cookie itself does not have the ability to automatically collect personal information about you. A cookie can store certain information that identifies your computer to us so that you do not need to re-enter that information as frequently when you use our site. The cookie does not contain your password.

We reserve the right to change our policy regarding cookies and the collection of information from visitors at any time without advance notice. Should any new policy be put into effect, we will post it on this website, and the new policy will apply only to information collected thereafter. You may opt out of receiving cookies or delete any prior cookies by changing your specific internet browser settings. The privacy of communication over the internet cannot be guaranteed. If you are concerned about the security of your communication, we encourage you to send your correspondence through the postal service or use the telephone to speak directly to us. We do not represent or warrant that the site, in whole or in part, is appropriate or available for use in any particular jurisdiction. Those who choose to access the site, do so on their own initiative and at their own risk, and are responsible for complying with all local laws, rules and regulations. We do not assume any responsibility for any loss or damage you may experience or incur by the sending of personal information over the internet by or to us. This Usage Agreement shall be governed by the laws of the United States and of the State of New Jersey, without giving effect to its conflict of laws provisions.

Please know that The Company has not and will not sell any consumers' personal information. We do not sell your nonpublic personal information to any third parties nor do we use it for marketing purposes.

How to contact us

If you have any questions about this Privacy Notice or about how we use the information we collect, please contact us at:

Crum & Forster Legal Department
305 Madison Avenue
Morristown, NJ 07960
privacyinformation@cfins.com

Changes to this Privacy Notice

We may revise this notice at any time. If we make material changes, we will notify you as required by law.

For California Residents Only:

If you are a California resident, you may be entitled to additional rights over your Information. We do not, and will not, sell Information collected from you. The California Consumer Privacy Act (CCPA) provides California residents, upon a verifiable consumer request, certain rights that include:

- ***The right*** to request that we disclose (1) The categories of personal information that we have collected about you; and (2) The categories of personal information that we have disclosed about you for a business purpose
- ***The right*** to request that we delete the personal information it has collected from you, subject to certain legal exceptions, for example, when such personal information is necessary to fulfill or comply with our legal obligations.

The right to be protected from discrimination for exercising your CCPA rights. If you choose to exercise your privacy rights, we will not charge you different prices or provide different quality of services unless those differences are related to your information.

You may designate an authorized agent to act on your behalf and make a request of us under the CCPA.

To exercise your rights under the CCPA or to seek assistance, please do one of the following:

- If you would like to make a Request to Know, go to http://www.cfins.com/request-to-know-california-residents/ or call 1.844.254.5754
- If you would like to make a Request to Delete, http://www.cfins.com/request-to-delete-california-residents/ or call 1.844.254.5754
- Fill out and send back to us the Request to Know / Request to Delete form to:
  Crum & Forster Legal Department
  PO Box 1973
  305 Madison Avenue
  Morristown, NJ 07962
  privacyinformation@cfins.com

We will attempt, where practical, to respond to your requests and to provide you with additional privacy-related information. We will confirm receipt of verifiable consumer requests within ten (10) days of receipt. You may only make a verifiable consumer request for personal information twice within a twelve (12) month period. We cannot respond to your request if we cannot verify your identity or authority to make the request and confirm the personal information relates to you. Any consumer with a disability may access this notice by contacting us at the address, email or toll free number listed above.

We may change this California Privacy Notice and our privacy practices over time. Our most current Privacy Policy and California Privacy Notice can be found on our website at http://www.cfins.com/terms/.

January 2020