The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

Group Policyholder: South Carolina Medical Association Members' Insurance Trust

In Consideration of the Group Policyholder's application for this Policy and payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the persons entitled to them.

The first premium for this Policy is due on its effective date. Subsequent premiums are due on November 1, 2016, and on the same day of each month after that. Policy anniversaries will be each January 1; unless shown otherwise on the Premium Rate Schedule inside.

The provisions and conditions set forth on the following pages are a part of this Policy, as fully as if recited over the signatures below.

This Policy is delivered in the State of South Carolina.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. The issue date of this Policy is October 1, 2016. This Policy supersedes and replaces any previously issued Policy with an effective date of October 1, 2016.

Charles A. Bradley
Secretary

Dennis R. Glass
President

THIS IS A LEGAL CONTRACT BETWEEN
THE POLICYHOLDER AND THE COMPANY

READ YOUR POLICY CAREFULLY

This is a limited benefit policy. It provides accident only insurance coverage.
There is no coverage for hospital, medical-surgical or major medical expenses.

GROUP ACCIDENT INSURANCE POLICY
No. GL 00040400346200000

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

CLASSIFICATION

Class 1 All Full-Time Employees Enrolled in the Medical Plan

ELIGIBILITY WAITING PERIOD (For Date Insurance Begins, Refer To "Effective Date" Section)

For Class 1: None

ANNUAL/OPEN ENROLLMENT PERIOD: December 1 – December 31

Coverage elected during this period will become effective on the later of:

(1) January 1 following the enrollment period, if Actively at Work on that day; or
(2) the day the Insured Person resumes Active Work, if not Actively at Work on the day the elected coverage or increase would otherwise take effect.

SCHEDULE OF BENEFITS
(Continued)

BENEFITS FOR SELECT PLAN – CLASS 1

ELIGIBLE CLASS means: All Full-Time Employees Enrolled in the Medical Plan

MINIMUM HOURS PER WEEK: 30

CONTRIBUTIONS: Insured Persons are required to contribute to the cost for Personal Accident Insurance.

EMERGENCY CARE BENEFITS

Type of Benefit	**Select Benefit Amount**
Ambulance Transportation	$150
Air Ambulance Transportation	$600
Emergency Care Treatment	$150
Initial Physician Office Visit	$50
Major Diagnostic Exam	$50

TREATMENT CARE BENEFITS

Type of Benefit	**Select Benefit Amount**
Hospital Admission	$1,000
Hospital Confinement	$200
Intensive Care Unit (ICU) Confinement	$400
Alternate Care and Rehabilitative Facility Confinement	$100
Follow-up Care	$50
Transportation	$150
Lodging	$100
Family Care	$20

SPECIFIC INJURIES OR TREATMENTS

Type of Injury/Treatment	**Select Benefit Amount**	
Fractures	Non-Surg	Surg
Ankle	$350	$700
Arm (shoulder to elbow)	$350	$700
Arm (elbow to wrist)	$350	$700
Bones of Face (except those listed below)	$300	$600
Coccyx	$300	$600
Collarbone	$350	$700
Elbow	$350	$700
Finger	$50	$100
Foot (except toes)	$350	$700
Hand (except fingers)	$350	$700
Hip	$1,500	$3,000
Kneecap	$350	$700
Leg (hip to knee)	$800	$1,600
Leg (knee to ankle)	$800	$1,600
Lower Jaw	$350	$700
Nose	$300	$600
Pelvis	$800	$1,600
Rib	$300	$600
Shoulder Blade	$350	$700
Skull (depressed)	$1,500	$3,000
Skull (non-depressed)	$800	$1,600
Sternum	$350	$700
Toe	$50	$100
Upper Jaw	$350	$700
Vertebrae	$300	$600
Vertebral Column	$800	$1,600
Wrist	$350	$700
Chip Fracture	25% of the fracture benefit	

SPECIFIC INJURIES (CONTINUED)

Type of Injury/Treatment	**Select Benefit Amount**	
Dislocations	Non-Surg	Surg
Ankle	$500	$1,000
Collarbone (sternoclavicular)	$500	$1,000
Collarbone (acromio and separation)	$300	$600
Elbow	$300	$600
Finger	$100	$200
Foot (except toes)	$500	$1,000
Hand (except fingers)	$300	$600
Hip	$1,500	$3,000
Knee (not kneecap)	$450	$900
Lower Jaw	$300	$600
Shoulder Blade	$300	$600
Toe	$100	$200
Wrist	$300	$600
Partial Dislocations	25% of the dislocation benefit	
Transfusions: Blood, Plasma, Platelets	$150	
Burns		
2nd Degree		
<9%	$100	
10-18%	$200	
19-36%	$400	
37% +	$800	
3rd Degree		
<9%	$800	
10-18%	$1,600	
19-36%	$3,200	
37% +	$6,400	
Skin Grafts (due to burns)	25% of the burn benefit	

SPECIFIC INJURIES (CONTINUED)

Type of Injury/Treatment	**Select Benefit Amount**
Coma	$5,000
Concussion	$100
Dental Injury - Emergency Dental Work for the following:	
Crown	$150
Extraction	$50
Eye Injury	
Surgical repair	$200
Removal of foreign body	$100
Joint Replacement	
Hip	$500
Knee	$500
Shoulder	$500
Lacerations	
No Sutures Required	$50
Sutures Required	
up to 5 cm	$100
5.1-15.5 cm	$200
15.6 cm+	$400
Knee Cartilage	$450
Ligaments/Tendons/Rotator Cuff	$450
Ruptured Disc	$600
Surgery - Abdominal or Thoracic	$1,000
Surgery - Arthroscopic	$250

TRANSITIONAL CARE BENEFITS

Type of Benefit	**Select Benefit Amount**
Medical Appliance Assistance	
Crutches	$25
Wheelchair - expected use less than 1 year	$50
Wheelchair - expected use 1 year or longer	$350
Walker - expected use less than 1 year	$25
Walker - expected use 1 year or longer	$50
Other Medical Appliance used for mobility	$25
Prosthesis	$500
Reasonable Modifications	$2,500

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (AD&D)

Type of Benefit	**Select Benefit Amount**
Loss	
Loss of Life	
Insured Person	$25,000
Loss of Hand, Foot, Arm, Leg, Eye, or Hearing in One Ear	$7,000
Any Loss of finger, thumb or toe	$300
Common Carrier Accident	2x benefit amt
Transportation of Remains	$5,000
Seat Belt/Air Bag/Helmet	10% of AD&D
Catastrophic Loss	$50,000
Loss of Sight in Both Eyes	
Loss of Hearing in Both Ears	
Loss of Speech	
Loss of Both Arms and Both Legs	
Loss of Both Arms	
Loss of Both Legs	
Loss of Arm and Leg	

DEFINITIONS

ACCIDENT or **ACCIDENTAL** refers to an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

ACTIVE WORK or ACTIVELY AT WORK means an Employee's performance of all customary duties of his or her occupation at:

(1) the Group Policyholder's place of business; or
(2) any other business location designated by the Group Policyholder.

Unless disabled on the prior workday or on the day of absence, an Employee will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday which is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.

AIRCRAFT means any device used for aerial navigation, including but not limited to, airplanes, helicopters, balloons, gliders, parachutes, hang gliders and parasails.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible Employees to purchase or make changes to their Personal Accident Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period.

CHIP FRACTURE means a fracture in which a piece of the bone is broken off.

CHILD CARE CENTER means any facility which:

(1) is licensed as such by the state;
(2) provides non-medical care and supervision for children in a group setting; and
(3) is not operated by the Insured Person or a member of the Insured Person's immediate family.

COMA means a state of complete mental unresponsiveness, due to Injury, with no evidence of appropriate responses to stimulation, as diagnosed by a Physician.

COMMON CARRIER means any land, air or water conveyance operated under a license to transport passengers for hire.

COMMON CARRIER ACCIDENT means a Covered Accident while the Insured Person is a fare-paying passenger on a Common Carrier.

COMPANION means a spouse, sibling, child, parent, grandparent, or any primary care giver.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

COVERED ACCIDENT means an Accident that:
(1) occurs while the Insured Person's coverage under this Policy is in effect;
(2) results in an Injury; and
(3) is not otherwise excluded under the terms of this Policy.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the Group Policyholder's place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

DISLOCATION means a completely separated joint. A Partial Dislocation means that the joint is misaligned, but not completely dislocated, as diagnosed by a Physician.

ELIGIBILITY WAITING PERIOD means the period of time a Person must be in an eligible class with the Group Policyholder, before he or she becomes eligible to enroll for insurance under this Policy.

EMERGENCY CARE FACILITY means an emergency room or urgent care facility recognized by the laws of the state where located.

EMPLOYEE means a Full-Time Employee of the Group Policyholder.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Group Policyholder's leave policy and the law which applies; and
(3) does not exceed the period approved by the Group Policyholder and required by that law.

The leave period may:
(1) consist of consecutive or intermittent work days; or
(2) be granted on a part-time equivalency basis.

If a Person is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If a Person is on an FMLA leave due to his or her own health condition on the date insurance under this Policy takes effect, he or she is not considered Actively at Work.

FRACTURE means a broken bone that can be determined by a diagnostic exam.

FULL-TIME EMPLOYEE means an owner or a person:
(1) whose employment with the Group Policyholder is the person's main occupation;
(2) whose employment is for regular wage or salary;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits per week;
(4) who is a member of an eligible class under this Policy;
(5) who is not a temporary or seasonal employee; and
(6) who is a citizen of the United States or legally works in the United States.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of this Policy.

HOME HEALTH CARE AGENCY means an agency that provides skilled nursing and other home health care services according to state and/or local laws on a visiting basis in the Insured Person's temporary or principal place of residence.

HOSPITAL means a general hospital which:
(1) is licensed, approved or certified by the state where it is located;
(2) is recognized by the Joint Commission;
(3) is operated to treat Inpatients;
(4) has a registered nurse always on duty; and
(5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:
(1) is specialized solely in dentistry, mental illness or substance abuse;
(2) is a rest home, home for the aged, convalescent home or nursing home; or
(3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

HOSPITAL CONFINEMENT means being a registered bed patient in a Hospital upon a Physician's recommendation. Such confinement must be medically necessary to diagnose or treat a covered Injury.

INPATIENT means an Insured Person who is an overnight resident patient.

INSURANCE MONTH means that period of time:
(1) beginning at 12:01 a.m. on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month;
at the Group Policyholder's primary place of business.

INSURED PERSON means a Person for whom Policy coverage is in effect.

INJURY OR INJURIES means bodily injury solely due to an Accident. It includes all complications of and all injuries received from the same Covered Accident.

INTENSIVE CARE UNIT (ICU) means a designated part of a Hospital that:

(1) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
(2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
(3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
(4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
(5) is assigned a Physician on a full-time basis.

LOSS, as used in the Dismemberment and Catastrophic Loss benefits, means severance or loss of function:

(1) of the hand through or above the wrist joint;
(2) of the foot through or above the ankle joint;
(3) of the arm above the elbow;
(4) of the leg above the knee;
(5) of sight in an eye, total and permanent loss of sight;
(6) of hearing, deafness in an ear that cannot be corrected to any functional degree by any procedure, aid or device;
(7) of speech, the loss of audible communication such that it cannot be corrected to any functional degree by any procedure, aid or device;
(8) of a finger or a thumb; or
(9) of a toe.

Loss of function means the total and irrevocable loss of use.

MEDICAL HEALTH PROFESSIONAL means a person, other than a Physician, that renders medical care and performs services that are within the scope of such person's license. Included in this definition are registered nurses, physician's assistants, and nurse practitioners.

MILITARY LEAVE means a leave of absence that:

(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Group Policyholder's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

OBSERVATION UNIT means a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician and which:

(1) is under the direct supervision of a Physician or registered nurse;
(2) is staffed by nurses assigned specifically to that unit; and
(3) provides care seven days per week, 24 hours per day.

OCCUPATIONAL THERAPIST means a person other than the Insured Person who:
(1) is licensed by the state to practice occupational therapy;
(2) performs services within the scope of his/her license; and
(3) practices according to the Code of Ethics of the American Occupational Therapy Association.

OUTPATIENT TREATMENT means medical services that an Insured Person receives when not confined as an Inpatient in a Hospital.

PAYROLL PERIOD means that period of time established by the Group Policyholder for payment of employee wages.

PERSON means a Full-Time Employee of the Group Policyholder:
(1) who is a member of a class that is eligible for insurance under this Policy; and
(2) who has completed an enrollment form.

PERSONAL ACCIDENT INSURANCE means the insurance provided by this Policy for Insured Persons.

PHYSICAL THERAPIST means a person other than the Insured Person who:
(1) is licensed by the state to practice physical therapy;
(2) performs services within the scope of his/her license; and
(3) practices according to the Code of Ethics of the American Physical Therapy Association.

PHYSICIAN means:
(1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
(2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:
(1) the Insured Person's spouse, siblings, parents, children and grandparents; and
(2) his or her spouse's relatives of like degree.

POLICY means this Group Accident Insurance policy issued by the Company to the Group Policyholder.

PREMIUM means the amount charged for insurance coverage.

SICKNESS means:
(1) illness;
(2) pregnancy; or
(3) infection, except when the infection is due to an Accidental cut or wound.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:
(1) this Policy and any amendments to it; and
(2) the Group Policyholder's application.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the insurance provided by this Policy, unless:
(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement has been furnished to that Insured Person.

AUTHORITY TO MAKE OR AMEND CONTRACT. Only a Company Officer located in the Company's Group Insurance Service Office has the authority to:
(1) determine the insurability of a group or any individual within a group;
(2) make a contract in the Company's name;
(3) amend or waive any provision of this Policy; or
(4) extend the time for payment of any premium.
No change in this Policy will be valid, unless it is made in writing and signed by such a Company Officer.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of this Policy after it has been in force for two years from its date of issue; and as to any Insured Person, after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) this Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of insurance.

NONPARTICIPATION. This is a non-participating policy. It will not share in the divisible surplus of any Company.

INFORMATION TO BE FURNISHED. The Group Policyholder may be required to furnish any information needed to administer this Policy, including:
(1) information about persons:
  (a) who become eligible for insurance;
  (b) whose amounts of insurance change; or
  (c) whose eligibility or insurance ends;
(2) occupational information and other facts that may be needed to manage a claim; and
(3) any other information that the Company may reasonably require.
The Company may inspect the Group Policyholder's records that relate to this Policy, at any reasonable time.

Clerical error by the Group Policyholder:
(1) will not void or terminate insurance that otherwise would be in effect;
(2) will not result in insurance coverage that otherwise would not be in effect; and
(3) will not continue insurance that otherwise would be terminated.
Once an error is discovered, a fair adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period that precedes the date the Company receives proof such an adjustment should be made.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under the Policy.
If any Insured Person's age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

ACTS OF THE POLICYHOLDER. In administering this Policy, the Group Policyholder must:
(1) treat Employees the same in like situations; and
(2) allow the Company, without inquiry, to rely on its acts.

GROUP POLICYHOLDER'S AGENCY. For all purposes of this Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CERTIFICATES. The Group Policyholder will be furnished with individual certificates of insurance for delivery to each Insured Person. These certificates summarize the benefits to which the Insured Person is entitled and to whom the benefits are payable. If there is a conflict between this Policy and the certificate, this Policy will control.

CONFORMITY WITH STATE STATUTES. If, on its effective date, any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

CURRENCY. In administering this Policy all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. This Policy does not replace or provide benefits required by:
(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Policy may not be assigned.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL ACCIDENT INSURANCE

ELIGIBILITY. A Person becomes eligible for insurance provided by this Policy on the latest of:

(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Benefits. Prior service in an Eligible Class will apply toward the Waiting Period, when:

(1) a former employee is rehired within 6 months after his or her employment ends; or
(2) an employee returns from an approved Family or Medical Leave within:
    (a) the leave period required by federal law; or
    (b) any longer period required by a similar state law; or
(3) an employee returns from a Military Leave within the period required by federal USERRA law.

ENROLLMENT. A Person may enroll for Personal Accident Insurance only:

(1) when first eligible; or
(2) during any Annual/Open Enrollment Period.

EFFECTIVE DATE. Personal Accident Insurance becomes effective on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the date the Person becomes eligible for the coverage;
(2) the date the Person resumes Active Work, if not Actively at Work on the day he or she becomes eligible. The Person will be deemed Actively at Work on any regular non-working day, if he or she:
    (a) is not totally disabled or Hospital confined on that day; and
    (b) was Actively at Work on the regular working day before that day; or
(3) if the Person contributes to the cost of the Personal Accident Insurance, the first day of the Insurance Month coinciding with or next following the date the Person makes written application for insurance and pays the required premium to the Company.

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the date on which the Insured Person becomes eligible for the increase, if Actively at Work on that day; or
(2) the day the Insured Person resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any reduction in insurance or benefits will take effect on the day of the change, whether or not the Insured Person is Actively at Work.

ANNUAL/OPEN ENROLLMENT PERIOD. A Person again becomes eligible to enroll, re-enroll, or change benefit options for Personal Accident Insurance under this Policy during the Group Policyholder's Annual/Open Enrollment Period.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL ACCIDENT INSURANCE (Continued)

REINSTATEMENT RIGHTS. If an Insured Person's insurance terminates due to one of the following breaks in service, he or she will be entitled to reinstate the insurance upon resuming Active Work with the Group Policyholder within the required timeframe. "**Reinstatement**" or "**to reinstate**" means to re-enroll for the Policy's insurance coverage, without satisfying a new Eligibility Waiting Period. Reinstatement is available upon:

(1) return from an approved Family or Medical Leave within:
    (a) the period required by federal law; or
    (b) any longer period required by a similar state law;
(2) return from a Military Leave within the period required by federal USERRA law; or
(3) return from any other approved leave of absence within 6 months after the leave begins.

To reinstate insurance coverage, the Person must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an eligible class unless the Group Policyholder contributes the entire cost of the premium. The required premium payments must be received from the Group Policyholder for coverage to be reinstated. Reinstatement will take effect on the date the Person returns to Active Work.

TERMINATION OF PERSONAL ACCIDENT INSURANCE

TERMINATION. An Insured Person's insurance will terminate at 12:00 midnight on the earliest of:

(1) the date this Policy terminates (but without prejudice to any claim incurred prior to termination);
(2) the date the Insured Person's Class is no longer eligible for insurance;
(3) the date the Insured Person ceases to be a member of the Eligible Class;
(4) the last day of the Insurance Month in which the Insured Person requests termination;
(5) the last day of the last Insurance Month for which premium payment is made on the Insured Person's behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the date the portion of this Policy providing that type of benefit terminates;
(8) the date the Insured Person's employment with the Group Policyholder terminates; or
(9) the date the Insured Person enters armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard (If the Person sends proof of military service, the Company will refund any unearned premium.);

unless insurance is continued as provided below.

CONTINUATION RIGHTS. Ceasing Active Work results in termination of the Insured Person's eligibility for insurance, but insurance may be continued as follows.

Disability. If the Insured Person is disabled due to illness or Injury, then insurance may be continued until the earlier of:

(1) 12 Insurance Months after the disability begins; or
(2) the date the Person is no longer disabled.

The required premium payments must be received from the Group Policyholder, throughout the period of continued insurance.

Family or Medical Leave. If an Insured Person goes on an approved Family or Medical Leave and is **not** entitled to any more favorable continuation available during disability, insurance may be continued until the earliest of:

(1) the end of the leave period approved by the Group Policyholder;
(2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
(3) the date the Insured Person notifies the Group Policyholder that he or she will not return; or
(4) the date the Insured Person begins employment with another employer.

The required premium payments must be received from the Group Policyholder throughout the period of continued insurance.

Military Leave. If an Insured Person goes on a Military Leave, insurance may be continued for the same period allowed for an approved Family or Medical Leave or any more favorable leave in which employees with similar seniority, status, and pay who are on furlough or leave of absence are granted by the Group Policyholder. The required premium payments must be received from the Group Policyholder throughout the period of continued insurance.

Lay Off or Other Leave. When an Insured Person ceases work due to a temporary layoff, or due to an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); insurance may be continued for three Insurance Months after the layoff or leave begins. The required premiums must be received from the Group Policyholder throughout the period of continued insurance.

Conditions. In administering the above continuations, the Group Policyholder must not act so as to discriminate unfairly among Insured Persons in similar situations. Insurance may not be continued when an Insured Person ceases Active Work due to a labor dispute, strike, work slowdown or lockout.

PORTABILITY. If insurance under this Policy would end for any reason other than nonpayment of premiums, the Insured Person has the option to continue Personal Accident Insurance. To continue insurance under this section, the Insured Person must:

(1) notify the Company within 31 days of the date the insurance would otherwise end; and
(2) pay the applicable premium to the Company.

Insurance continued under this section ends on the earliest of:

(1) the last day of the period for which the Insured Person paid premiums; or
(2) the date the Company receives a written request from the Insured Person to terminate the insurance.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while the Insured Person was insured under this Policy.

PREMIUMS AND PREMIUM RATES

PAYMENT OF PREMIUMS. No insurance provided by this Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Group Policyholder is responsible for paying all premiums as they become due.

GRACE PERIOD. A grace period of 60 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the grace period, unless the Group Policyholder gives the Company advance written notice of termination. The Group Policyholder will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

PREMIUM RATE CHANGE. The Company may change any premium rate:

(1) the date this Policy's terms are changed; or
(2) the date the Company's liability is changed due to a change in federal, state or local law;
(3) the date the Company's liability is changed because the Group Policyholder (or any covered division, subsidiary or affiliated company) relocates, dissolves or merges, or is added to or removed from this Policy; or
(4) on any premium due date after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company, for all policies of like class.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 31 days advance written notice of any increase in premium rates.

PREMIUM AMOUNT. The amount of premium due on each due date will be the total of the premium amounts obtained by multiplying:

(1) each rate shown in the Premium Rate Schedule; by
(2) the number of Insured Persons electing each rate.

For premium purposes, the effective date of any change in insurance is the first day of the Insurance Month which coincides with or follows the change. Changes will not be pro-rated daily.

PREMIUM RATE SCHEDULE

Monthly Accident Rates

Select Plan	
Class 1 - All Full-Time Employees Enrolled in the Medical Plan	
Personal Accident Only insurance	$9.95

POLICY TERMINATION

TERMINATION BY THE COMPANY. This Policy is issued for an indefinite term. The Policy will continue in force as long as premiums are paid when due, unless terminated for one of the following reasons:

(1) the Group Policyholder, without good cause, fails to:
   (a) promptly furnish any information which the Company may reasonably require; or
   (b) perform its duties pertaining to this Policy in good faith; or
(2) state law otherwise requires this Policy to be terminated.

To terminate this Policy, the Company must give the Group Policyholder at least 31 days advance written notice of its intent to do so.

TERMINATION BY GROUP POLICYHOLDER. The Group Policyholder may terminate this Policy at any time by giving the Company advance written notice. Insurance will then terminate:

(1) on the date the Company receives the notice; or
(2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination.

AUTOMATIC TERMINATION. If any premium remains unpaid at the end of the Grace Period; then this Policy will automatically terminate, without any action on the Company's part, on the last day of the Grace Period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

EFFECT ON INCURRED CLAIMS. Termination of this Policy will not affect benefits otherwise payable for a claim incurred while this Policy is in force.

EMERGENCY CARE BENEFITS

For Select Plan

The Company will pay one or more of the following emergency care benefits if an Insured Person meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

AMBULANCE TRANSPORTATION. The Company will pay an Ambulance Transportation benefit if a licensed ambulance company transports an Insured Person by ground transportation to or from a Hospital or between medical facilities, for treatment of Injuries sustained as a result of a Covered Accident. The ambulance transportation must be within 90 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

AIR AMBULANCE TRANSPORTATION. The Company will pay an Air Ambulance Transportation benefit if a licensed ambulance company transports an Insured Person by air ambulance to or from a Hospital or between medical facilities for treatment of Injuries sustained as the result of a Covered Accident. The air ambulance transportation must be within 48 hours of the Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit may be paid in addition to the Ambulance Transportation benefit.

EMERGENCY CARE TREATMENT. The Company will pay an Emergency Care Treatment benefit if an Insured Person is examined or treated in an Emergency Care Facility as a result of a Covered Accident. The emergency care treatment must be received within 72 hours of a Covered Accident. This benefit will be paid once per person per Covered Accident.

INITIAL PHYSICIAN OFFICE VISIT. The Company will pay an Initial Physician Office Visit benefit if an Insured Person is examined or treated by a Physician or Medical Health Professional in an office of practice as a result of a Covered Accident. The examination or treatment must be administered within 60 days of a Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit will not be payable if an Insured Person receives payment for the Emergency Care Treatment benefit, as described above.

MAJOR DIAGNOSTIC EXAM. The Company will pay a Major Diagnostic Exam benefit if an Insured Person undergoes one of the following major diagnostic exams as a result of a Covered Accident:

(1) a computed tomography (CT or CAT) scan;
(2) a magnetic resonance imaging (MRI);
(3) a positron emission tomography (PET) scan;
(4) an electroencephalography (EEG);
(5) a spectroscopy (SPECT);
(6) a joint imaging scan;
(7) a diffusion tensor imaging (DTI) scan; or
(8) a magneticresonsance angiogram (MRA) scan.

A major diagnostic exam must be prescribed by a Physician and performed within 60 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

TREATMENT CARE BENEFITS

For Select Plan

The Company will pay one or more of the following treatment care benefits if an Insured Person meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

HOSPITAL ADMISSION. The Company will pay a Hospital Admission benefit if an Insured Person is admitted to a Hospital as a result of a Covered Accident. The admission must occur within 180 days of a Covered Accident. The Company will not pay this benefit for emergency room treatment, Outpatient Treatment, or a stay of less than 20 hours in an Observation Unit. This benefit is payable once per person per Covered Accident.

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement benefit for each day an Insured Person is confined in a Hospital as the result of a Covered Accident. The initial confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 365 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accident. In the event this Hospital Confinement benefit and an Intensive Care Unit Confinement benefit are payable on the same day, only the Intensive Care Unit Confinement benefit will be paid.

INTENSIVE CARE UNIT (ICU) CONFINEMENT. The Company will pay an ICU Confinement benefit for each day or partial day an Insured Person is confined in an ICU as the result of a Covered Accident. The confinement must begin within 30 days of a Covered Accident. The ICU confinement period begins on the day of admission to the ICU and ends on the day of discharge from the ICU. This benefit will be paid for up to 15 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one ICU Confinement at a time, even if it is caused by more than one Covered Accident. In the event this ICU Confinement benefit and the Hospital Confinement benefit are payable on the same day, only the ICU benefit will be paid. If an Insured Person exhausts the ICU benefit but is still confined, the Insured Person may be eligible for the Hospital Confinement benefit.

ALTERNATE CARE AND REHABILITATIVE FACILITY CONFINEMENT. The Company will pay an Alternate Care and Rehabilitative Facility Confinement benefit for each day an Insured Person is confined on an Inpatient basis in an Alternate Care or Rehabilitative Facility as a result of a Covered Accident. The confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 90 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Alternate Care or Rehabilitative Facility Confinement at a time, even if it is caused by more than one Covered Accident. The Alternate Care and Rehabilitative Facility Confinement benefit will not be paid on any day when the Hospital or ICU Confinement benefit is paid.

FOLLOW-UP CARE. The Company will pay a Follow-Up Care benefit for each occurrence of follow-up care for Physician treatment, physical therapy, occupational therapy, or home health care that results from Injuries sustained by an Insured Person. Follow-up care must be received within 365 days of a Covered Accident. Follow-up care must be provided by a Physician, Medical Health Professional, Physical Therapist, Occupational Therapist or a Home Health Care Agency. This benefit is payable for up to 6 times per person per Covered Accident. This benefit is not payable while the Insured Person is confined in a Hospital, ICU, or an Alternate Care or Rehabilitative Facility.

TRANSPORTATION. The Company will pay a Transportation benefit when the Insured Person must travel more than 100 miles one way for treatment at a Hospital or other specialized freestanding treatment facility. The treatment must be prescribed by a Physician and not available locally. This benefit is payable up to three times per person per Covered Accident. This benefit is not payable when transportation is provided by ambulance or air ambulance.

LODGING. The Company will pay a Lodging benefit for each day a Companion accompanies an Insured Person who is Hospital confined more than 100 miles from the Insured Person's principal place of residence due to a Covered Accident. The Companion must stay in a hotel, motel or Hospital-sponsored hospitality suite. This benefit is payable for up to 30 days, within 365 days of the Covered Accident.

FAMILY CARE. The Company will pay the Family Care benefit if:

(1) an Insured Person is confined in a Hospital, ICU or Alternate Care or Rehabilitative Facility as a result of a Covered Accident; and
(2) the Insured Person has a child or children attending a Child Care Center.

The benefit is payable for each child attending a Child Care Center on any given day the Insured Person is confined. The child attending a Child Care Center does not need to be insured under this Policy for this benefit to be payable. This benefit is payable for up to 30 days, within 365 days of the Covered Accident. The Company will pay only one Family Care benefit per child.

SPECIFIC INJURIES OR TREATMENTS

For Select Plan

The Company will pay one or more of the following specific injuries or treatments benefits if an Insured Person meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

FRACTURE. The Company will pay a Fracture benefit when an Insured Person sustains a Fracture or Chip Fracture as a result of a Covered Accident. The Fracture or Chip Fracture must be diagnosed by a Physician within 90 days of a Covered Accident.

DISLOCATION. The Company will pay a Dislocation benefit when an Insured Person sustains a Dislocation or Partial Dislocation as a result of a Covered Accident. The Dislocation or Partial Dislocation must be diagnosed by a Physician within 90 days of a Covered Accident.

BLOOD, PLASMA, PLATELETS. The Company will pay a benefit for an Insured Person's:

(1) transfusion;
(2) administration;
(3) cross-matching; or
(4) typing and processing;

of blood, plasma, or platelets administered as a result of a Covered Accident, provided this is done within 90 days of such Covered Accident. This benefit is payable once per person per Covered Accident.

BURNS. The Company will pay a Burn benefit when an Insured Person sustains a 2nd or 3rd degree burn as a result of a Covered Accident. The 2nd or 3rd degree burn must be treated by a Physician within 72 hours of a Covered Accident. If the burns meet more than one of the Burn benefit classifications shown in the Schedule of Benefits, the Company will pay the single highest benefit amount. This benefit is payable once per person per Covered Accident.

SKIN GRAFT. The Company will pay a Skin Graft benefit when grafting of the skin is necessary for a burn that was payable under the Burn benefit. This benefit is payable once per person per Covered Accident.

COMA. The Company will pay a Coma benefit if an Insured Person has been in a Coma for 15 or more days as a result of a Covered Accident. This benefit is payable once per person per Covered Accident.

CONCUSSION. The Company will pay a Concussion benefit if the Insured Person sustains a concussion as a result of a Covered Accident. The concussion must be diagnosed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

DENTAL INJURY. The Company will pay a Dental Injury benefit if an Insured Person's natural teeth are damaged and:

(1) extracted; or
(2) repaired by placement of a crown;

by a Dentist as a result of a Covered Accident. Initial treatment must be received within 7 days of a Covered Accident. This benefit is payable for up to one crown and one extraction per person per Covered Accident, regardless of the number of teeth involved.

SPECIFIC INJURIES OR TREATMENTS
(Continued)
For Select Plan

EYE INJURY. The Company will pay an Eye Injury benefit if an Insured Person injures an eye (or eyes) in a Covered Accident and:

(1) surgical repair is performed by a Physician within 90 days of a Covered Accident; or
(2) a Physician removes an embedded foreign body from the Insured Person's eye, with or without anesthesia, within 90 days of a Covered Accident.

This benefit is payable once for each eye per person per Covered Accident.

JOINT REPLACEMENT. The Company will pay a Joint Replacement benefit when an Insured Person sustains an Injury requiring a hip, knee, or shoulder joint replacement as a result of a Covered Accident. The joint replacement must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable for each required replacement per person per Covered Accident.

LACERATION. The Company will pay a Laceration benefit when an Insured Person sustains a laceration as a result of a Covered Accident. The laceration must be treated by a Physician or Medical Health Professional within 72 hours of a Covered Accident. This benefit is payable:

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

per person as a result of any one Covered Accident.

KNEE CARTILAGE. The Company will pay a Knee Cartilage benefit when an Insured Person sustains an Injury requiring the surgical repair or removal of torn knee cartilage as a result of a Covered Accident. The surgical repair or removal must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

TENDON/LIGAMENT/ROTATOR CUFF. The Company will pay the Tendon/Ligament/Rotator Cuff benefit when an Insured Person requires surgical repair of:

(1) tendons;
(2) ligaments; or
(3) the muscles or tendons that make up the rotator cuff;

as a result of a Covered Accident. The surgical repair must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

RUPTURED DISC. The Company will pay the Ruptured Disc benefit when an Insured Person sustains an Injury requiring surgical repair of a ruptured intervertebral disc as a result of a Covered Accident. The ruptured disc must be surgically repaired by a Physician within 90 days of a Covered Accident. This benefit is payable once per disc per person per Covered Accident.

SURGERY (ABDOMINAL OR THORACIC). The Company will pay the Surgery (Abdominal or Thoracic) benefit when an Insured Person undergoes abdominal or thoracic surgery as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

SURGERY (ARTHROSCOPIC). The Company will pay a Surgery (Arthroscopic) benefit when an Insured Person undergoes arthroscopic surgery, with no repair, as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSITIONAL CARE BENEFITS

For Select Plan

The Company will pay one or more of the following transitional care benefits if an Insured Person meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

MEDICAL APPLIANCE ASSISTANCE. The Company will pay a benefit for Medical Appliances that are required by an Insured Person as a result of Injuries sustained in a Covered Accident. The Medical Appliance must be recommended by a Physician or Medical Health Professional and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the Medical Appliance must be recommended by a Physician or Medical Health Professional and received within two years of the Covered Accident. This benefit is payable once for any one Medical Appliance per person per Covered Accident.

Medical Appliance means an item that is intended by its manufacturer for use in directly substituting for a malfunctioning part of the body for assistance with mobility. Examples include crutches, wheel chairs and walkers.

PROSTHESIS. The Company will pay a benefit for functional prosthetic limbs that are required by an Insured Person as a result of Injuries sustained in a Covered Accident. The functional prosthetic limb must be prescribed by a Physician and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the prosthetic limb must be prescribed by a Physician and received within two years of the Covered Accident. This benefit is payable once per limb per person per Covered Accident.

REASONABLE MODIFICATIONS. The Company will pay a benefit for required modifications made to an Insured Person's:

(1) principal place of residence; or
(2) vehicle;

provided the Insured Person suffers a Catastrophic Loss, as described in the Schedule of Benefits. Modifications must be made within two years from the date of the Covered Accident. This benefit is payable once per person per Covered Accident.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

For Select Plan

The Company will pay one or more of the following AD&D benefits if an Insured Person meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH OR DISMEMBERMENT. The Company will pay an Accidental Death or Dismemberment benefit when an Insured Person sustains an Injury that causes death or dismemberment as a result of a Covered Accident. The Injury must cause death or dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss.

The Accidental Dismemberment benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when an Insured Person sustains a Common Carrier Accident that results in the Insured Person's death or dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSPORTATION OF REMAINS. The Company will pay a Transportation of Remains benefit if the Insured Person dies at least 100 miles from his or her principal place of residence as a result of a Covered Accident, and the bodily remains or ashes are returned:

(1) by a company that provides mortuary transport services; and
(2) to a mortuary or funeral home within 30 miles of the deceased Insured Person's principal place of residence.

The Company will pay for only one Transportation of Remains benefit per person.

A benefit payable for the transportation of an Insured Person's remains will be paid in accord with the Beneficiary provision.

SEAT BELT/HELMET. If an Insured Person:

(1) was wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
(2) suffers an AD&D loss;

the Accidental Death or Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when an Insured Person sustains an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

LIMITATIONS AND EXCLUSIONS

For Class 1

This Policy covers only Injuries that occur while insurance is in force. Benefits are not payable for any loss if the loss resulting, directly or indirectly, from or was in any degree caused by:

(1) disease, physical or mental infirmity, Sickness, or medical or surgical treatment of these;
(2) intentional self-inflicted injury or self-destruction, or any attempt thereof; suicide or suicide attempt, whether sane or insane;
(3) deliberate use of drugs, poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, except when administered within the therapeutic levels and dosage prescribed by a licensed Physician;
(4) participation in, commission of or attempt to commit a felony;
(5) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind;
(6) duty as a member of any military, including Reserves or National Guard;
(7) travel or flight in or on any Aircraft, except:
    (a) as a fare-paying passenger on a regularly scheduled commercial flight; or
    (b) as a passenger or pilot in the Group Policyholder's aircraft while flying on the Group Policyholder's business provided:
        (i) the aircraft has a valid U.S. airworthiness certificate (or foreign equivalent); and
        (ii) the pilot has a valid pilot's certificate with a non-student rating authorizing him to fly the aircraft;
(8) the Insured Person having a blood alcohol level of .08 grams of alcohol or more per 100 milliliters of blood;
(9) Injury arising out of or in the course of any employment for wage or profit;
(10) high risk sports or extreme sports such as, but not limited to, bungee jumping, parachuting, base jumping, or mountaineering;
(11) cosmetic or elective surgery;
(12) being incarcerated in any type of penal or detention facility;
(13) participating in or practicing for, or officiating any semi-professional or professional sport;
(14) riding in or driving in any motor driven vehicle for race, stunt show or speed test; or
(15) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At the death of an Insured Person, any amount payable as a result of his or her death will be paid to the named Beneficiary who survives the Insured Person. If the Insured Person has not named a Beneficiary, or if no named Beneficiary survives the Insured Person; then payment will be made to the Insured Person's:

(1) surviving spouse; or, if none
(2) surviving child or children in equal shares; or, if none
(3) surviving parent or parents in equal shares; or, if none
(4) surviving sibling or siblings in equal shares; or, if none
(5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

(1) within 15 days of the Insured Person's death; and
(2) before the Company receives satisfactory proof of the Insured Person's death;

payment will be made as if the Insured Person had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. An Insured Person's Beneficiary will be as shown on his or her enrollment form, unless changed. If this Policy replaces a group policy providing similar coverages; then an Insured Person's beneficiary named under the prior policy will be the Beneficiary under this Policy, until changed.

CHANGING THE BENEFICIARY. Only the Insured Person or his or her assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change with the Company at its Group Insurance Service Office prior to the Insured Person's death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under this Policy becomes payable to an Insured Person's estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

(1) a person who has assumed the care and support of the Insured Person or Beneficiary;
(2) a person who has incurred expense as a result of the Insured Person's last illness or death;
(3) the personal representative of the Insured Person's estate; or
(4) any person related by blood or marriage to the Insured Person.

No payment made to anyone named above may exceed $1,000. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

(1) the Group Policyholder's name and Policy number;
(2) the Insured Person's name, address and certificate number, if available; and
(3) the patient's name and relationship to the Insured Person.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then the Person may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of services; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

(1) the nature, date and cause of the claim;
(2) a description of the services provided; and
(3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

(1) any study models, treatment records or charts;
(2) copies of any x-rays or other diagnostic materials; and
(3) any other items the Company may reasonably require.

*** Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While an Accident claim is pending, the Company may have the claimant examined:

(1) by a Physician of its Choice;
(2) as often as is reasonably required.

Any such exam will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Accident benefits payable under this Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE

Accidental Death & Dismemberment. Benefits due to loss of the Insured Person's life will be paid in accord with the Beneficiary provision. All other benefits will be paid to the Insured Person.

Other Accident Benefits. Any other Accident benefits will be paid to the Insured Person, unless an overpayment has been made and the Company is entitled to reduce future benefits.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

(1) the reason for the denial, under the terms of this Policy and any internal guidelines;
(2) how the claimant may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within 90 days after receiving the first proof of a death or other Accident claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within 180 days after receiving the first proof of a death or other Accident claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of a death or other Accident claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

(1) any further appeal procedures available under this Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

For a death or other Accident claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the Insured Person a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

(1) the Company's error in processing a claim;
(2) the claimant's receipt of benefits or services under another plan;
(3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than six years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that this Policy clearly reserves to the Group Policyholder, the Company has the authority to:

(1) manage this Policy and administer claims under it; and
(2) interpret the provisions and to resolve questions arising under this Policy.

The Company's authority includes (but is not limited to) the right to:

(1) establish and enforce procedures for administering this Policy and claims under it;
(2) determine eligibility for insurance and entitlement to benefits;
(3) determine what information the Company reasonably requires to make such decisions; and
(4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:

(1) request a state insurance department review; or
(2) bring legal action.

The Lincoln National Life Insurance Company
Group Insurance Service Office
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

Office Use Only ID# _____

APPLICATION FOR GROUP INSURANCE

is hereby made to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company).

A. NAME AND ADDRESS

1. **Applicant's Full Legal Name** (exactly as to be shown in Group Policy): South Carolina Medical Association Members' Insurance Trust

2. **Main Office Address** (physical location and group situs state):

Street 132 Westpark Blvd. City Columbia State SC

Zip 29210 Phone # (803) 798-6207 FAX # (803) 750-1115 E-Mail Address (if available) _____

B. REQUESTED COVERAGES

The following Group Insurance is applied for as specified in the sold case proposal(s). Complete the requested Effective Date for each coverage.

- [x] Life & AD&D with Effective Date 10/01/2016
- [ ] Long Term Disability with Effective Date _____
- [x] Short Term Disability with Effective Date 10/01/2016
- [ ] Dental with Effective Date _____
- [x] Accident with Effective Date 10/01/2016
- [ ] Critical Illness with Effective Date _____
- [ ] Voluntary Life with Effective Date _____
- [x] Voluntary Life & AD&D with Effective Date 10/01/2016
- [ ] Voluntary Long Term Disability with Effective Date _____
- [ ] Voluntary Short Term Disability with Effective Date _____
- [ ] Voluntary Dental with Effective Date _____

C. BUSINESS INFORMATION

1. **Nature of Business** (Please specify): Self Insured Health Insurance Program

Years in Business 30+ Federal Tax ID# 91-1839164

2. **Business is Organized As** (select one):
   - [ ] Corporation
   - [x] Non-Profit Organization
   - [ ] Partnership
   - [ ] Proprietorship
   - [ ] Other _____

3. **Financial Risk** (If Yes to any part, please explain below.)
   - [ ] Yes [x] No Has Applicant ever filed for bankruptcy?
   - [ ] Yes [x] No Does Applicant anticipate ceasing or materially reducing active business operations?
   - [ ] Yes [x] No Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation?

Explanation: _____

4. **Binder** payment submitted: Amount $ 0.00 (if applicable)

D. REPLACEMENT COVERAGE

[x] Yes [ ] No Will all or part of this coverage **replace** any similar coverage? **If Yes, provide details of the prior plan below and enclose a copy of each inforce contract to be replaced.**

Coverage Type	Prior Carrier Name	Prior Plan Effective Date	Termination Date
Life/ADD	Mutual Of Omaha	1/1/2014	09/30/2016
STD	Mutual of Omaha	1/1/2014	09/30/2016
Vol Life/ADD	Mutual of Omaha	1/1/2014	09/30/2016
Accident	Mutual of Omaha	1/1/2015	09/30/2016

E. FRAUD WARNING

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents a false information in a an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award from insurance proceeds shall be reported to the Colorado Division of insurance within the Department of Regulatory Services.

DC: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KENTUCKY: Any person who knowingly and with the intent to defraud an insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information containing any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA & RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

OTHER STATES (EXCEPT KANSAS): A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

F. AGREEMENT. The Applicant hereby applies for group insurance. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will:

(a) be issued only if the requested insurance is acceptable to the Company and is legally permissible;
(b) be issued under a group Policy or Policies in the language customarily used by the Company;
(c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
(d) be subject to all exclusions and limitations of the Policy; and
(e) take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to any Active Work requirement. The Applicant agrees not to:

(a) collect or pay premiums (other than the Binder Premium, if any) for such insurance, before receiving the Company's notice of approval; or
(b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

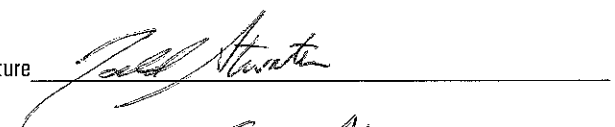
If dental insurance is requested, the Applicant agrees to provide employees and dependents notice of any applicable continuation rights, required by federal COBRA law or any similar state continuation law. Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This application and the Binder payment, if any, constitutes the consideration for any Policy issued. After receipt of the Policy, payment of the premium is deemed acceptance of the Policy's terms. If this Application is approved, it will be made a part of any Policy issued.

Writing Agent
Or Broker's Signature 

Typed or Printed Name Stewart Samples

License Number _____ State _____

Signed by Applicant's Authorized Representative:

Signature 

Typed or Printed Name Todd Atwater

Title CEO

State Signed S.C. Date 7/31/16

Must be signed prior to Effective Date