

UNITED STATES FIRE INSURANCE COMPANY

Administrative Office: 5 Christopher Way
Eatontown, New Jersey 07724
(Hereinafter referred to as "the Company")

TRAVEL PROTECTION INSURANCE

Certificate of Insurance

This Certificate of Insurance describes all of the travel insurance benefits underwritten by United States Fire Insurance Company, herein referred to as the Company. The insurance benefits vary from program to program. Please refer to the accompanying Confirmation of Benefits. It provides the Insured with specific information about the program he or she purchased. The Insured should contact the Company immediately if he or she believes that the Confirmation of Benefits is incorrect.

Insurance provided by this Certificate is subject to all of the terms and conditions of the Group Policy. If there is a conflict between the Policy and Certificate, the Policy will govern.

If the Insured is not completely satisfied with the insurance he or she must notify the Company within ten (10) days of purchase and return the certificate. The Company will give the Insured a full refund of premium provided he or she has not already departed on the Covered Trip or filed a claim.

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



Marc J. Adee
Chairman and CEO



James Kraus
Secretary

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CONFIRMATION OF BENEFITS

Travel Arrangement Protection

Benefit Per Trip	Maximum Benefit Amount/Principal Sum
Trip Interruption	up to \$1,000
Missed Connection	up to \$1,500
Travel Delay ▪ Maximum per Day: \$200	up to \$750
Itinerary Change	\$250
Baggage and Personal Effects	\$1,500
Baggage Delay ▪ Maximum per Day: \$150	up to \$750

Travel Insurance Benefits

Accidental Death & Dismemberment	
Accidental Death & Dismemberment	up to \$50,000
Medical Expense/Emergency Assistance	
Accident & Sickness Medical Expense	up to \$100,000
Emergency Medical Evacuation	up to \$1,000,000

SECTION I. COVERAGES

COVERAGE A

ACCIDENTAL DEATH AND DISMEMBERMENT

This Coverage A Benefit is provided only if shown as covered on the Confirmation of Benefits.

An insured is eligible for benefits twenty-four (24) hours a day, up to the Maximum Benefit shown, when he or she sustains an Injury during the Covered Trip that results in a loss noted below within one hundred-eighty (180) days of the date of the Injury causing the loss.

Table of Losses	
Type of Loss	Benefit Amount
Loss of Life	100% of Principal Sum
Loss of both hands	100% of Principal Sum
Loss of both feet	100% of Principal Sum
Loss of both eyes	100% of Principal Sum
Loss of one hand and one foot	100% of Principal Sum
Loss of one hand and one eye	100% of Principal Sum
Loss of one foot and one eye	100% of Principal Sum
Loss of one hand	50% of Principal Sum
Loss of one foot	50% of Principal Sum
Loss of one eye	50% of Principal Sum

Loss of hand or hands, or foot or feet, means severance at or above the wrist joint or ankle joint, respectively.

Loss of eye or eyes means the total and irrecoverable loss of the entire sight thereof.

Only one of the amounts shown above (the largest applicable) will be paid for Injuries resulting from one accident.

The benefit for loss of: (a) two limbs; (b) both eyes; or (c) one limb and one eye is payable only when such loss results from the same accident.

These benefits will not duplicate any benefits payable under the policy or any coverages provided herein.

The Principal Sum is shown in the Confirmation of Benefits.

COVERAGE B

ACCIDENT MEDICAL EXPENSE

This Coverage B Benefit is provided only if shown as covered on the Confirmation of Benefits.

For purposes of this benefit:

“Covered Expense” means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which are limited to:

1. the services of a Legally Qualified Physician;
2. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured’s Covered Trip, if recommended as a substitute for a hospital room for recovery of an Injury);
3. transportation furnished by a professional ambulance company to and/or from a Hospital; and prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the Covered Expense incurred, up to the Maximum Benefit Amount, if an Insured incurs a Covered Expense as a result of an accidental Injury, which occurs during the Covered Trip. Only Covered Expenses incurred during the Covered Trip will be reimbursed. Expenses incurred after the Covered Trip are not covered.

Benefits will include expenses for emergency dental treatment for Injury not to exceed seven hundred fifty dollars (\$750).

Benefits will not be paid in excess of the Usual and Customary Charges.

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure an Insured's admission to a Hospital, because of a covered accidental Injury. The authorized travel assistance company will coordinate advance payment to the Hospital.

NEW YORK MANDATES: Under New York Law, certain mandated benefits are required to be provided under a medical expense policy. The Company will pay benefits as applicable to this program for such mandates.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE C

SICKNESS MEDICAL EXPENSE

This Coverage C is made a part of the policy to which it is attached. It is subject to all policy provisions of this Coverage C.

For purposes of this benefit:

"Covered Expense" means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which are limited to:

1. the services of a Legally Qualified Physician;
2. Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured's Covered Trip, if recommended as a substitute for a hospital room for recovery of a Sickness);
3. transportation furnished by a professional ambulance company to and/or from a Hospital; and
4. prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the Covered Expense incurred, up to the Maximum Benefit Amount, if an Insured incurs a Covered Expense as a result of Sickness, which manifests itself during the Covered Trip. Only Covered Expenses incurred during the Covered Trip will be reimbursed. Expenses incurred after the Covered Trip are not covered.

Benefits will include expenses for emergency dental treatment not to exceed seven hundred fifty dollars \$750.

Benefits will not be paid in excess of the Usual and Customary Charges.

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure an Insured's admission to a Hospital, up to the Maximum Benefit Amount, because of a covered Sickness. The authorized travel assistance company will coordinate advance payment to the Hospital.

NEW YORK MANDATES: Under New York Law, certain mandated benefits are required to be provided under a medical expense policy. The Company will pay benefits as applicable to this program for such mandates.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE D

TRIP INTERRUPTION

This Coverage D Benefit is provided only if shown as covered on the Confirmation of Benefits.

Benefits will be paid, up to the Maximum Benefit Amount, for the non-refundable, unused portion of the prepaid expenses for Travel Arrangements and/or the additional cost for one-way Economy Transportation for the Insured to return to their original destination or rejoin their Trip less the value of the original unused return travel ticket when an Insured is prevented from completing his or her Trip due to:

1. Sickness, Injury or death involving You or Your Traveling Companion or You or Your Business Partner, or Your Family Member which results in medically imposed restrictions as certified by a Legally Qualified Physician at the time of loss preventing the Insured's continued participation in the Trip;
2. Unannounced Strike that causes complete cessation of services of the Insured's Common Carrier for at least twelve (12) consecutive hours;
3. Weather that causes complete cessation of services of the Insured's Common Carrier for at least twelve (12) consecutive hours;

4. Employer termination or layoff affecting the Insured or a person(s) sharing the same room with the Insured during the Insured's Covered Trip. Employment must have been with the same employer for at least three (3) continuous years;
5. An Insured's or Traveling Companion's principal place of residence being rendered uninhabitable by unforeseen circumstances or fire or flood or burglary of primary residence during the Insured's Covered Trip;
6. Bankruptcy or Default of an airline or cruise line, or tour operator or travel supplier (Other than the tour operator or travel agency from whom the Insured purchased their travel arrangements) which stops service more than fourteen (14) days following the Insured's Effective Date and after the Insured's Covered Trip. departure. This benefit only applies if the policy has been purchased within twenty (20) days of the Insured's initial payment for the Covered Trip and for the full cost of the Covered Trip.
7. Terrorism in a country which is part of the Trip, which causes the United States Department of State to issue a travel warning that an Insured should not travel within that country for a period of time that would include the Trip. Such travel warning must be made after the Effective Date;
8. Hijack, quarantine, jury duty, or court ordered appearance as a witness in a legal action in which an Insured or Traveling Companion is not a party (except law enforcement officers);
9. The Insured or Traveling Companion is called to emergency military duty for national disaster other than war;
10. Traffic accident, substantiated by a police report, directly involving either the Insured or Traveling Companion while en route to a scheduled point of departure;
11. If the Travel Supplier cancels Your Trip, You are eligible for the benefit amount shown in the Confirmation of Benefits for the reissue fee charged by the airline for each of the Insureds' tickets. You must have protected the entire cost of their Trips, including the airfare.
12. Natural disaster at the site of the Insured's destination, which renders their destination accommodations uninhabitable;
13. A Terrorist Incident that occurs in a city listed on the itinerary of the Insured's Covered Trip and within thirty (30) days prior to the Insured's Scheduled Departure Date. This same city must not have experienced a Terrorist Incident within the ninety (90) days prior to the Terrorist Incident that is causing the Insured's cancellation of the Covered Trip. Benefits are not provided if the Travel Supplier offers a substitute itinerary.;
14. The Insured's family or friends living abroad with whom the Insured was planning to stay, are unable to provide accommodations due to life threatening illness, life threatening injury or death of one of them

Provided such circumstances occurred after the Insured's Effective Date and during the Insured's Covered Trip.

If a Traveling Companion must remain hospitalized, benefits will also be paid for reasonable accommodation and transportation expenses incurred by an Insured to remain with the traveling companion up to two hundred one hundred fifty dollars (\$200) per day and limited to five (5) days.

If an Insured cannot continue travel due to a covered Injury or Sickness not requiring hospitalization, and an Insured must extend his or her Covered Trip with additional hotel nights up to one hundred fifty dollars (\$150) per day and limited to five (5) days due to medically imposed restrictions, as certified by a Legally Qualified Physician.

If the Insured's Travel Supplier cancels Insured's Covered Trip, the Insured is covered up to one hundred fifty dollars (\$150.00) for the reissue fee charged by the airline for the tickets. The Insured must have covered the entire cost of the Covered Trip including the airfare.

The maximum payable under this benefit is the lesser of: a) total cost of the Insured's Covered Trip; or b) the total amount of coverage the Insured purchased.

All cancellations must be reported to the Travel Supplier within seventy-two (72) hours of the event causing the need to cancel. If the event delays the reporting of the cancellation beyond the seventy-two (72) hours, the event should be reported as soon as possible. All other delays of reporting beyond seventy-two (72) hours will result in reduced benefit payments.

COVERAGE E

BAGGAGE AND PERSONAL EFFECTS

This Coverage E Benefit is provided only if shown as covered on the Confirmation of Benefits.

For purposes of this benefit:

“Baggage and Personal Effects” means goods being used by an Insured during a Covered Trip. The term Baggage and Personal Effects does not include:

1. animals;
2. automobiles and automobile equipment;
3. boats or other vehicles or conveyances;
4. trailers;
5. motors;
6. aircraft;
7. bicycles, except when checked as baggage with a Common Carrier;
8. household effects and furnishings;
9. antiques and collectors’ items;
10. sunglasses, contact lenses, artificial teeth, dental bridges or hearing aids;
11. prosthetic limbs;
12. prescribed medications;
13. keys, money, credit cards (except as coverage is otherwise specifically provided herein);
14. securities, stamps, tickets and documents (except as coverage is otherwise specifically provided herein);
15. professional or occupational equipment or property, whether or not electronic business equipment; or
16. telephones, computer hardware or software;

For Baggage and Personal Effects: Coverage will be provided to an Insured: (a) against all risks of permanent loss, theft or damage to baggage and personal effects; (b) subject to all Exclusions and Limitations in the policy; (c) up to the Maximum Benefit Amount; and (d) occurring while this coverage is in force.

The lesser of the following amounts will be paid:

- (a) the actual cash value (cost less proper deduction for depreciation) at the time of loss, theft or damage;
- (b) the cost to repair or replace the article with material of a like kind and quality; or
- (c) three hundred dollars (\$300) per article.

A combined maximum of six hundred dollars (\$600) will be paid for jewelry, watches, articles consisting in whole or in part of silver, gold or platinum, articles trimmed with fur, cameras and their accessories and related equipment.

A maximum of fifty dollars (\$50) will be paid for the cost of replacing a passport or visa.

A maximum of fifty dollars (\$50) will be paid for the cost associated with the unauthorized use of lost or stolen credit cards, subject to verification that the Insured has complied with all conditions of the credit card company.

For Baggage Delay: If, while on a Covered Trip, an Insured’s checked baggage is delayed or misdirected by a Common Carrier for more than twelve (12) hours from his or her time of arrival at a destination other than at his or her place of permanent residence, benefits will be paid, up to the Maximum Benefit Amount, for the actual expenditure for necessary personal effects. An Insured must be a ticketed passenger on a Common Carrier. The Common Carrier must certify the delay or misdirection. Receipts for the purchases must accompany any claim.

Benefits will not be paid for any expenses which have been reimbursed or for any services which have been provided by the Common Carrier, hotel or Travel Supplier; nor will benefits be paid for loss or damage to property specifically schedule under any other insurance.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE F

TRIP DELAY

This Coverage F Benefit is provided only if shown as covered on the Confirmation of Benefits.

If an Insured is delayed for eight (8) hours or more hours while en route to or from a Covered Trip, due to:

- (a) any delay of a Common Carrier. The delay must be certified by the Common Carrier;

- (b) a traffic accident in which an Insured or Traveling Companion are not directly involved (must be substantiated by a police report);
- (c) lost or stolen passports, travel documents or money (must be substantiated by a police report); or
- (d) quarantine, hijacking, terrorism, strike, natural disaster, or riot;
- (e) documented weather condition preventing the Insured from getting to the point of departure;

Benefits will be paid, on a one-time basis, up to the Maximum Benefit Amount, for:

- (a) the Additional Transportation Cost from the point where an Insured was delayed to a destination where he or she can join the Covered Trip;
- (b) the Additional Transportation Cost to return an Insured to his or her originally scheduled return destination;
- (c) reasonable accommodation and meal expenses up to two hundred dollars (\$200) per day necessarily incurred by an Insured for which he or she has proof of purchase and which were not paid for or provided by any other source; and
- (d) the non-refundable, unused portion of the prepaid expenses for the Covered Trip as long as the expenses are supported by proof of purchase and are not reimbursable by any other source.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE G

EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION AND RETURN OF REMAINS

This Coverage G Benefit is provided only if shown as covered on the Confirmation of Benefits.

When an Insured suffers loss of life for any reason or incurs a Sickness or Injury during the course of a Covered Trip, the following benefits are payable, up to the Maximum Benefit Amount.

1. **For Emergency Medical Evacuation:** If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.
 - (a) If an Insured is in the Hospital for more than three (3) consecutive days and the Insured's dependent children who are under eighteen (18) years of age and accompanying an Insured on the Covered Trip, are left unattended, Economy Transportation will be paid to return the dependents to their home (with an attendant, if considered necessary by the travel assistance company).
 - (b) If an Insured is in a traveling alone and is the Hospital for more than three (3) consecutive days and Emergency Evacuation is not imminent, upon request of the Insured or next of kin if Insured is incapacitated benefits will be paid to transport one (1) person, chosen by the Insured, by Economy Transportation, for a single visit to and from his or her bedside.
2. **For Medical Repatriation:**
 - (a) If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for an Insured to return to his or her place of permanent residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for an Insured's return to his or her permanent residence via:
 - (i) one-way Economy Transportation; or
 - (ii) commercial upgrade, based on an Insured's condition as recommended by the local attending Legally Qualified Physician and verified in writing.
 - (iii) Transportation must be via the most direct and economical route.
 - (b) If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for an Insured to return to his or her place of permanent residence for continued treatment of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for transportation to the Hospital or medical facility closest to an Insured's permanent place of residence capable of providing that treatment. Transportation must be by the most direct and economical route. Covered land or air transportation includes, but is not limited to, commercial stretcher, medical escort,

or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company.

3. **For Return of Remains:** In the event of an Insured's death, the expense incurred will be paid for minimally necessary casket or air tray, preparation and transportation of an Insured's remains to his or her place of residence or to the place of burial.

If benefits are payable under this Coverage G and an Insured has other insurance that may provide benefits for this same loss, the Company reserves the right to recover from such other insurance. An Insured shall:

- (a) notify the Company of any other insurance;
- (b) help the Company exercise the Company's rights in any reasonable way that the Company may request, including the filing and assignment of other insurance benefits;
- (c) not do anything after the loss to prejudice the Company's rights; and
- (d) reimburse to the Company, to the extent of any payment the Company has made, for benefits received from such other insurance.

Benefits are paid less the value of the Insured's original unused return travel ticket.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE H

ITINERARY CHANGE

This Coverage H Benefit is provided only if shown as covered on the Confirmation of Benefits.

In the event a cruise/tour supplier makes a change in the Insured's Covered Trip itinerary after the Insured's Scheduled Departure Date, which prevents the Insured from participating in an event/activity pre-paid prior to departure and scheduled on the Insured's Covered Trip itinerary, nonrefundable pre-paid event/activity expenses will be payable up to the Maximum Benefit Amount.

Benefits will not be paid if a comparable event/activity cost is rescheduled during the course of the Covered Trip.

Verification by the cruise/tour supplier of the change in the scheduled Covered Trip itinerary will be necessary for claim payment.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE I

MISSED CONNECTION

This Coverage I is made a part of the policy to which it is attached. It is subject to all policy provisions of this Coverage I.

If an Insured misses his or her cruise or tour departure because their airline flight is delayed for three (3) or more hours, due to:

- (a) any delay of a Common Carrier. The delay must be certified by the Common Carrier;
- (b) documented weather condition preventing the Insured from getting to the point of departure;
- (c) quarantine, hijacking, Strike, natural disaster, terrorism or riot;

Benefits will be paid, on a one-time basis, up to the Maximum Benefit Amount, for:

- (a) the Additional Transportation Cost to join the Covered Trip;
- (b) reasonable accommodation and meal expenses up to one hundred fifty dollars (\$150) per day necessarily incurred by an Insured for which he or she has proof of purchase and which were not paid for or provided by any other source;"

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

SECTION II. DEFINITIONS

"Additional Transportation Cost" means the actual cost incurred for one-way Economy Transportation by Common Carrier reduced by the value of an unused travel ticket.

“Bankruptcy” means the filing of a petition for voluntary or involuntary bankruptcy in a court of competent jurisdiction under Chapter 7 or Chapter 11 of the United States Bankruptcy Code 11 L.S.C. Subsection 101 et seq.

“Business Partner” means an individual who (a) is involved in a legal general partnership with an Insured and or (b) is actively involved in the day to day management of an Insured’s business.

“Common Carrier” means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire.

“Confirmation of Benefits” means the coverage confirmation provided to an Insured following enrollment and payment of the applicable premium.

“Covered Trip” means scheduled trips, tours or cruises for which (a) coverage is requested: and (b) the required premium is submitted prior to the Scheduled Departure Date.

“Default” means the inability to provide contracted services due to a material financial failure.

“Domestic Partner” means a person who is at least eighteen (18) years of age and can show: 1) evidence of financial interdependence, such as joint bank accounts or credit cards, jointly owned property, and mutual life insurance or pension beneficiary designations; 2) evidence of continuous cohabitation throughout the one hundred eighty (180) day period prior to the Insured’s Effective Date of the Plan; and 3) an affidavit of domestic partnership if recognized by the jurisdiction within which they reside.

“Economy Transportation” means the lowest published available transportation rate for a ticket on a Common Carrier matching the original class of transportation that the Insured purchased for the Covered Trip, reduced by the value of an unused return travel ticket.

“Family Member” means any of the following: an Insured’s or an Insured’s Traveling Companion’s: legal spouse (or common-law spouse where legal), legal guardian, son or daughter (adopted, foster, step or in-law), brother or sister (includes step or in-law), parent (includes step or in-law), grandparent (includes in-law), grandchild, aunt, uncle, niece or nephew, Domestic Partner, an employed caregiver who lives with the Insured, or a person for whom the Insured is the primary caregiver with whom the Insured have lived for twelve (12) continuous months prior to the effective date of the Insured’s Plan, whether or not they travel with the Insured.

“Hospital” means a short-term, acute, general hospital, that

- (a) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- (b) has organized departments of medicine and major surgery;
- (c) has a requirement that every patient must be under the care of a physician or dentist;
- (d) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- (e) if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395x[k]);
- (f) is duly licensed by the agency responsible for licensing such hospitals; and

Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

“Inclement Weather” means any weather condition that delays the scheduled arrival or departure of a Common Carrier.

“Injury” or “Injuries” means accidental bodily injuries: (a) received while insured under the Policy and any attached coverages: (b) resulting in loss independently of sickness and all other causes: and (c) not excluded from coverage.

“Insured” means the individual named on the enrollment form who has purchased a Covered Trip and who has paid the required premium.

“Intoxicated” mean a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where an Insured is located at the time of an incident.

“Legally Qualified Physician” means a physician or a Christian Science Practitioner (a) other than an Insured, a Traveling Companion or a Family Member: (b) practicing within the scope of his or her license: and (c) recognized as a physician in the place where the services are rendered.

“Maximum Benefit Amount” means the maximum amount payable for coverage provided to an Insured as shown in the Confirmation of Benefits.

“Medical Treatment” means treatment advice or consultation by a Legally Qualified Physician.

“Medically Necessary” means a service or supply which: (a) is recommended by the attending Legally Qualified Physician: (b) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice: (c) could not have been omitted without adversely affecting an Insured’s condition or quality of medical care: (d) is delivered at the most appropriate level of care and not primarily for the sake of convenience: and (e) is not considered experimental unless coverage for experimental services or supplies is required by law.

“Mental or Nervous Conditions” 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, including but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, bipolar Affective Disorder or Autism.

“Pre-existing Condition” means the existence of symptoms in You, Your Traveling Companion, Your Family Member or Business Partner booked to travel with him or her. [You, Your Business Partner’s or Traveling Companion’s Family Member that would ordinarily cause a prudent person to seek diagnosis, care or treatment within a sixty (60) day period preceding the effective date of Your coverage, or a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a sixty (60) day period preceding the effective date of Your coverage.

“Published Penalties” means any published cancellation penalties issued by the Your travel agency or Travel Supplier that apply to all clients of the travel agency or Travel Supplier and can be documented at time of Trip sale. The Insured must be in the Travel Supplier’s penalty period. The maximum amount reimbursable under the travel agencies published penalties is twenty-five percent (25%) of the total trip cost (excluding taxes and other non-commissionable items) or ten percent (10%) of the amount the Insured has paid, whichever is less. Maximum payable under any one claim is the Covered Trip cost, excluding taxes and other non-commissionable items.

“Scheduled Departure Date” means the date on which an Insured is originally scheduled to leave on the Covered Trip.

“Scheduled Return Date” means the date on which an Insured is originally scheduled to return to the point of origin or the original final destination.

“Sickness” means an illness or disease that is diagnosed or treated by a Legally Qualified Physician after the effective date of insurance and while the Insured is covered under the Policy.

“Strike” means any stoppage of work: (a) as a result of a combined effort of workers which was unannounced and unpublished at the time travel services were purchased: and (b) which interferes with the normal departure and arrival of a Common Carrier.

“Terrorist Incident” means an incident deemed a terrorist act by the United States Government that causes property damage and loss of life.

“Third Party” means a person or entity other than an Insured or the Company.

“Transportation Expense” means: (a) the cost of conveyance of an Insured and any medical personnel (if Medically Necessary): and (b) Medically Necessary services or supplies.

“Travel Arrangements” means: (a) transportation: (b) accommodations: and (c) other specified services arranged by the Travel Supplier for the covered trip.

“Traveling Companion” means a person or persons with whom the Insured has coordinated Travel Arrangements and intends to travel with during the Covered Trip. Note, a group or tour leader is not considered a Traveling Companion unless the Insured is sharing room accommodations with the group or tour leader.

“Travel Supplier” means any entity or organization that coordinates or supplies travel services for an Insured.

“Usual and Customary Charges” means those comparable charges for similar treatment, services and supplies in the geographic area where treatment is performed.

SECTION III. INSURING PROVISIONS

Insured’s Term of Coverage:

For Trip Delay: Coverage is in force while en route to and from the Covered Trip.

For all other coverages: Coverage begins at the point and time of departure on the Scheduled Departure Date. Coverage ends at the point and time of return on an Insured’s Scheduled Return Date.

In the event the Scheduled Departure Date and/or the Schedule Return Date are delayed, or the point and time of departure and/or point and time of return are changed because of circumstances over which neither the Travel

Supplier nor an Insured has control an Insured's term of coverage shall be automatically adjusted accordance with the Travel Supplier's notice to the Company of the delay or change.

SECTION IV. GENERAL LIMITATIONS AND EXCLUSIONS

Benefits are not payable for Sickness, Injuries or losses of an Insured, his or her Traveling Companion, Insured's or Traveling Companion's Family Member, or Insured's Business Partner:

1. resulting from suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane;
2. resulting from an act of declared or undeclared war;
3. while participating in maneuvers or training exercises of an armed service;
4. while riding, driving or participating in races, or speed or endurance contests (This exclusion does not apply to the accident and health benefits payable under the Certificate);
5. while mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment) (This exclusion does not apply to the accident and health benefits payable under the Certificate);
6. while participating as a member of a team in an organized sporting competition;
7. while participating in skydiving, hang gliding, bungee cord jumping, scuba diving if the depth exceeds one hundred twenty (120) feet or if the Insured is not certified to dive and a dive master is not present during the dive; or deep-sea diving (This exclusion does not apply to the accident and health benefits payable under the Certificate);
8. while piloting or learning to pilot or acting as a member of the crew of any aircraft;
9. received as a result or consequence of being Intoxicated, as specifically defined in the policy, or under the influence of any controlled substance unless administered on the advise of a Legally Qualified Physician;
10. to which a contributory cause was the commission of or attempt to commit a felony or being engaged in an illegal occupation;
11. due to normal childbirth, normal pregnancy (except complications of pregnancy or voluntarily induced abortion);
12. for dental treatment (except as coverage is otherwise specifically provided herein);
13. which exceed the Maximum Benefit Amount for each attached coverage as shown in the Confirmation of Benefits: or;
14. due to a Pre-existing Condition, as defined in the Policy. The Pre-existing Condition Limitation does not apply to: (a) Emergency Medical Evacuation, Medical Repatriation and Return of Remains coverage; or (b) to coverage purchased within twenty (20) days from the time the initial Covered Trip deposit is paid and if the Insured is medically able to travel when payment is made for the insurance.
15. due to a mental or nervous condition, unless hospitalized;

Additional Limitations and Exclusions Specific to Baggage and Personal Effects

Benefits are not payable for any loss caused by or resulting from:

- (a) breakage of brittle or fragile articles;
- (b) wear and tear or gradual deterioration;
- (c) confiscation or appropriation by order of any government or custom's rule;
- (d) theft or pilferage while left in any unlocked vehicle;
- (e) property illegally acquired, kept, stored or transported;
- (f) an Insured's negligent acts or omissions; or
- (g) property shipped as freight or shipped prior to the Scheduled Departure Date.

SECTION V. GENERAL PROVISIONS

Notice of Claim: Notice of claim must be reported within twenty (20) days after a loss occurs or as soon as is reasonably possible. An Insured or someone on an Insured's behalf may give the notice. The notice should be given to the Company or designated representative and should include sufficient information to identify the Insured.

Claim Forms: When notice of claim is received by the Company or designated representative, forms for filing proof of loss will be furnished. If these forms are not sent within fifteen (15) days, the proof of loss requirements can be met by sending a written statement of what happened. This statement must be received within the time given for filing proof of loss.

Proof of Loss: Proof of loss must be provided within ninety (90) days after the date of the loss or as soon as is reasonably possible, except in the absence of legal capacity.

Time of Payment of Claims: The Company, or its designated representative, will pay the claim after receipt of acceptable proof of loss.

Payment of Claims: Benefits for loss of life are payable to the Principal Insured, who is the beneficiary for all other Insureds. If: (a) the Principal Insured predeceases an Insured; and (b) a beneficiary is not otherwise designated by the Principal Insured benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

- (a) the Principal Insured's spouse;
- (b) the Principal Insured's child or children jointly;
- (c) an Insured's parents jointly if both are living or the surviving parent if only one (1) survives;
- (d) an Insured's brothers and sisters jointly; or
- (e) the Principal Insured's estate.

All or a portion of all other benefits provided by the Policy may, at the option of the Company, be paid directly to the provider of the service(s). All benefits not paid to the provider will be paid to the Principal Insured.

Other than for loss of life, if any benefit is payable to: (a) an Insured or the Principal Insured's beneficiary who is minor or otherwise not able to give a valid release; or (b) the Principal Insured's estate: the Company may pay up to one thousand dollars (\$1,000) to the Principal Insured's beneficiary or any relative to whom the Company finds entitled to the payment. Any payment made in good faith shall fully discharge the Company to the extent of such payment.

Physician Examination and Autopsy: The Company, at the expense of the Company, may have an Insured examined when and as often as is reasonable while the claim is pending. The Company may have an autopsy done (at the expense of the Company) where it is not forbidden by law.

Legal Actions: No legal action for a claim can be brought against us until sixty (60) days after we receive proof of loss. No legal action for a claim can be brought against us more than three (3) years after the time required for giving proof of loss. This three (3) year time period is extended from the date proof of loss is filed and the date the claim is denied in whole or in part.

Concealment and Misrepresentation: The entire coverage will be void, if before, during or after a loss, any material fact or circumstance relating to this insurance has been concealed or misrepresented.

Other Insurance with the Company: An Insured may be covered under only one travel policy with the Company for each Covered Trip. If an Insured is covered under more than one such policy, he or she may select the coverage that is to remain in effect. In the event of death, the selection will be made by the beneficiary or estate. Premiums paid (less claims paid) will be refunded for the duplicate coverage that does not remain in effect. (This provision does not apply to the Accident Medical Expense or the Sickness Medical Expense Benefits if provided under this Certificate.)

Subrogation: If the Company has made a payment for a loss under this coverage, and the person to or for whom payment was made has a right to recover damages from the Third Party responsible for the loss, the Company will be subrogated to that right. An Insured shall help the Company exercise the Company's rights in any reasonable way that the Company may request: nor do anything after the loss to prejudice the Company's rights; and in the event an Insured recovers damages from the Third Party responsible for the loss, the Insured will hold the proceeds of the recover for the Company in trust and reimburse the Company to the extent of the Company's previous payment for the loss.

Additional Claims Provisions Specific to Baggage: Insured's Duties After Loss of or Damage to Property or Delay of Baggage: In case of loss, theft, damage or delay of baggage or personal effects, and Insured must:

- (a) take all reasonable steps to protect, save or recover the property;
- (b) promptly notify, in writing, either the police, hotel proprietors, ship lines, airlines, railroad, bus, airport or other station authorities, tour operators or group leaders, or any Common Carrier or bailee who has custody of an Insured's property at the time of loss;
- (c) produce records needed to verify the claim and its amount, and permit copies to be made:

- (d) provide to the Company, within ninety (90) days from the date of loss, a detailed proof of loss signed and sworn to: and
- (e) be examined, if requested.

Reductions in the Amount of Insurance: The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid for any loss or damage under this coverage for this Covered Trip.

SECTION VI. COORDINATION OF BENEFITS

Applicability

The Coordination of Benefits (“COB”) provision applies to This Plan when an Insured has health care coverage under more than one Plan. “Plan” and “This Plan” are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- (a) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
- (b) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described further in the section entitled Effect on the Benefits of This Plan.

Definitions

“**Plan**” is a form of coverage written on an expense incurred basis that provides benefits or services for, or because of, medical or dental care or treatment. “Plan” includes:

- (a) group insurance and group remittance subscriber contracts;
- (b) uninsured arrangements of group coverage;
- (c) group coverage through HMO’s and other prepayment, group practice and individual practice Plans; and
- (d) blanket contracts, except blanket school accident coverages or a similar group when the Policy:

“**Plan**” does not include individual or family: (a) insurance contracts; (b) direct payment subscriber contracts; (c) coverage through HMO’s; or (d) coverage under other prepayment, group practice and individual practice Plans.

“**This Plan**” is the parts of this blanket contract that provide benefits for health care expenses on an expense incurred basis.

“**Primary Plan**” is one whose benefits for a person’s health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either:

- (a) the Plan either has no order of benefit determination rules, or it has rules which differ from those in the contract; or
- (b) all Plans that cover the person use the same order of benefits determination rules as in this contract, and under those rules the Plan determines its benefits first.

“**Secondary Plan**” is one that is not a Primary Plan. If a person is covered by more than one (1) Secondary Plan, the order of benefit determination rules of this contract decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan, which, under the rules of this contract, has its benefits, determined before those of that Secondary Plan.

“**Allowable Expense**” is the necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part under any of the Plans involved.

The difference between the cost of a private hospital room and a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient’s stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an Allowable Expense and a benefit paid.

“**Claim**” is a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of: (a) services (including supplies); (b) payment for all or a portion of the expenses incurred; or (c) a combination of (a) and (b).

“Claim Determination Period” is the period of time, which must not be less than twelve (12) consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine: (a) whether overinsurance exists; and (b) how much each Plan will pay or provide.

For the purposes of this contract, Claim Determination Period is the period of time beginning with the effective date of coverage and ending twelve (12) consecutive months following the date of loss or longer as may be determined by the proof of loss provision.

Order of Benefit Determination Rules

When This Plan is a Primary Plan, its benefits are determined before those of any other Plan and without considering another Plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of any other Plan only when, under these rules, it is secondary to that other Plan.

When there is a basis for a Claim under This Plan and another Plan, This Plan is a Secondary Plan that has its benefits determined after those of the other Plan, unless:

- (a) the other Plan has rules coordinating its benefits with those of This Plan; and
- (b) both those rules and This Plan’s rules, as described below, require that This Plan’s benefits be determined before those of the other Plan.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- (a) **Nondependent/Dependent Rule.** The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan that covers the person as a dependent.
- (b) **Longer/Shorter Length of Coverage Rule.** The benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter time.

To determine the length of time a person has been covered under a Plan, two (2) Plans shall be treated as one if the claimant was eligible under the second within twenty-four (24) hours after the first ended. Thus, the start of a new Plan does not include: (a) a change in the amount or scope of a Plan’s benefits; (b) a change in the entity which pays, provides or administers the Plan’s benefits; or (c) a change from one (1) type of Plan to another. The claimant’s length of time covered under a Plan is measured from the claimant’s first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant’s coverage under the present Plan has been in force.

Effect on the Benefits of This Plan When it is Secondary

The benefits of This Plan will be reduced when it is a Secondary Plan so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the Claim is made. As each Claim is submitted, This Plan determines its obligation to pay for Allowable Expenses based on all Claims that were submitted up to that point in time during the Claim Determination Period.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts are needed. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the Claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable monetary value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of: (a) the persons we have paid or for whom we have paid; (b) insurance companies; or (c) other organizations.

Non-complying Plans

This Plan may coordinate its benefits with a Plan that is excess or always secondary or which uses order of benefit determination rules which are inconsistent with those of This Plan (non-complying Plan) on the following basis:

- (a) If This Plan is the Primary Plan, This Plan will pay its benefits on a primary basis;
- (b) if This Plan is the Secondary Plan, This Plan will pay its benefits first, but the amount of the benefits payable will be determined as if This Plan were the Secondary Plan. In this situation, our payment will be the limit of This Plan's liability; and
- (c) if the non-complying Plan does not provide the information needed by This Plan to determine its benefits within thirty (30) days after it is requested to do so, we will assume that the benefits of the non-complying Plan are identical to This Plan and will pay benefits accordingly. However, we will adjust any payments made based on this assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

THE UNITED STATES FIRE INSURANCE COMPANY
Administrative Office: 5 Christopher Way, Eatontown, NJ 07724

**NEW YORK
EXTERNAL APPEAL**

YOUR RIGHT TO AN EXTERNAL APPEAL

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State of New York to conduct such appeals.

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY

If we have denied coverage on the basis that the service is not medically necessary, you may appeal to an external appeal agent if you satisfy the following two criteria:

The service, procedure, or treatment must otherwise be a Covered Service under the Certificate; and

You must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial **or** we and you must agree to waive any internal appeal.

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two criteria:

The service must otherwise be a Covered Service under the Certificate; and You must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial **or** we and you must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered under the Certificate or one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State of New York in order to obtain current information as to what documents will be considered or acceptable); or A clinical trial for which you are eligible (only certain clinical trials can be considered).

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

THE EXTERNAL APPEAL PROCESS

If, through the first level of our internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have forty-five (45) days from receipt of such notice to file a written request for an external appeal. If you and we have agreed in writing to waive any internal appeal, you have forty-five (45) days from receipt of such waiver to file a written request for an external appeal. We will provide an external appeal application with the final adverse determination issued through the first level of our internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Insurance Department at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application.

If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which we based our denial, the external appeal agent will share this information with us in order for to exercise our right to reconsider its decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited appeal (described below), we do have a right to reconsider our decision.

In general, the external appeal agent must make a decision within thirty (30) days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or from us. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and us by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns our decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, we will provide coverage subject to the other terms and conditions of the Certificate. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and us. The external appeal agent's decision is admissible in any court proceeding.

At our option, we may choose to charge you a fee of fifty dollars (\$50) for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. We will waive the fee if we determine that paying the fee would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee will be refunded to you.

YOUR RESPONSIBILITIES

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Insurance Department. You may appoint a representative to assist you with your external appeal request, however, the Insurance Department may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for appeal must be filed within forty-five (45) days of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Plan has no authority to grant an extension of this deadline.

COVERED SERVICES/EXCLUSIONS

In general, we do not cover experimental or investigational treatments. However, we will cover an experimental or investigational treatment approved by an external appeal agent in accordance with the terms of the Certificate. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs that would not be covered under the Certificate for non-experimental or non-investigational treatments provided in such clinical trial.

Signed for The United States Fire Insurance Company By:



Marc J. Adee
Chairman and CEO

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 reason(s) 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 that was 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 by telephoning Us within sixty (60) days after an event that causes a dispute. Telephoning Us allows You to discuss Your complaint or concerns and provides Us the opportunity to immediately resolve the dispute.

If We do not have all the information necessary to review Your complaint, We will request any additional information within five (5) business days of receiving Your complaint. After We receive all of the additional information, We will provide You, Your authorized representative, or a provider acting on Your behalf with Our written decision within thirty (30) days after receiving the complaint and all additional 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 three (3) working business days after receiving the Grievance, We must acknowledge the Grievance and provide You, Your authorized representative or a provider acting on your behalf 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. You will not be allowed to attend, or have a representative attend, a First Level Review. You 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 twenty (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 You 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 (10) business days after receiving a request for a Second Level Review, We will advise You of the following:

1. the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
2. a statement of Your rights, including the right to:
 - (a) attend the Second Level Review;
 - (b) present Your case to the review panel;
 - (c) submit supporting materials before and at the review meeting;
 - (d) ask questions of any member of the review panel;
 - (e) be assisted or represented by a person of Your choice, including a provider, family member, employer representative, or attorney;
 - (f) 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 forty-five (45) days after receiving a request for a Second Level Review. We will notify You in writing of the meeting date at least fifteen (15) days prior to the date. The review meeting will be held during regular business hours at a location reasonably accessible to You. In cases where a face-to-face meeting is not practical for 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 fifteen (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 (1) 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 (1) of our employees on the Second Level Review panel if the panel is comprised of three (3) or more persons.

We must issue a written decision to You and, if applicable, to Your representative or provider, within ten (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 do not have the information necessary to decide an appeal, We will send You notification of precisely what is required within twenty-four (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 seventy-two (72) hours after the review has commenced. Written confirmation of Our decision will be provided within two (2) working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

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

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

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

United States Fire Insurance Company
PRIVACY POLICY AND PRACTICES

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

Your Privacy is Our Concern

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

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

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

What do we do with the information collected about you?

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

To whom do we disclose information about you?

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

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

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

How to contact Us

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

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