

**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 Schedule 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 Schedule of Benefits is incorrect.

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



Marc J. Adeo  
Chairman and CEO



James Kraus  
Secretary

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 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.

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**SCHEDULE OF BENEFITS**

<b><u>Benefit</u></b>	<b><u>Maximum Benefit Amount/Principal Sum</u></b>
<b>Part B – Travel Arrangement Protection</b>	
Trip Cancellation.....100% of Trip Cost up to a maximum of \$5,000	
Trip Interruption.....100% of Trip Cost up to a maximum of \$5,000	
Baggage & Personal Effects.....	\$2,000
Baggage Delay (Up to \$50 Per Day).....	\$150
Trip Delay (Up to \$500 Per Day).....	\$2,500

## SECTION I. COVERAGES

### TRIP CANCELLATION

This Benefit is provided only if shown as covered on the Schedule of Benefits.

Benefits will be paid up to the Maximum Benefit Amount, to cover an Insured for the non-refundable Published Penalties and prepaid expenses for Travel Arrangements when an Insured is prevented from taking his or her Covered Trip due to:

1. death of an Insured, Traveling Companion or Business Partner, or Family Member of an Insured or Traveling Companion;
2. a covered Sickness or Injury involving an Insured, Traveling Companion or Business Partner, or Family Member of an Insured or Traveling Companion which necessitates Medical Treatment at the time of cancellation and results in medically imposed restrictions, as certified by a Legally Qualified Physician, which prevents an Insured's participation in the Covered Trip;
3. an Insured being hijacked, quarantined, required to serve on a jury (notice of jury duty must be received after the Effective Date) served with a court order to appear as a witness in a legal action in which an Insured or Traveling Companion is not a party (except law enforcement officers);
4. an Insured's principal place of residence being rendered uninhabitable by unforeseen circumstances; burglary of residence within 10 days of departure; or felonious assault within 10 days of departure;
5. an Insured being directly involved in a traffic accident, which must be substantiated by a police report, while en route to an Insured's scheduled point of departure;
6. Natural disaster at the site of the Insured's destination, which renders their destination accommodations uninhabitable limited to the cost of the airfare of the Insured's Covered Trip;
7. Felonious Assault of the Insured within 10 days of the scheduled Departure Date;
8. An Insured is in the Military and called to emergency duty for a national disaster other than war;
9. 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 1 continuous years; provided such circumstances occurred after the Insured's Effective Date.
10. Revocation of Your previously granted military leave or re-assignment due to war. Official written revocation/re-assignment by a supervisor or commanding officer of the appropriate branch of service will be required.

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

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.

#### Single Supplement

Benefits will be paid, up to the Maximum Benefit Amount, for the additional cost incurred as a result of a change in the per person occupancy rate for prepaid Travel Arrangements if a Traveling Companion has his or her Covered Trip delayed, canceled or interrupted for a covered reason and an Insured does not cancel.

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

Amount is shown in the Schedule of Benefits.

### TRIP INTERRUPTION

This Benefit is provided only if shown as covered on the Schedule 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. Death of an Insured, Traveling Companion or Business Partner, or Family Member of an Insured or Traveling Companion;
2. A covered Sickness or Injury involving an Insured, Traveling Companion or Business Partner, or Family Member of an Insured or Traveling Companion which necessitates Medical Treatment at the time of interruption and results in medically imposed restrictions, as certified by a

Legally Qualified Physician, which prevents an Insured's continued participation in the Covered Trip;

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 \$100 per day and limited to 5 days due to medically imposed restrictions, as certified by a Legally Qualified Physician.

If the Insured's Travel Supplier cancels the Insured's Covered Trip, the Insured is covered up to \$250.00 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 air.

The combined 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.

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

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

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

### **BAGGAGE AND PERSONAL EFFECTS**

This Benefit is provided only if shown as covered on the Schedule 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:

- a) animals;
- b) automobiles and automobile equipment;
- c) boats or other vehicles or conveyances;
- d) trailers;
- e) motors;
- f) aircraft;
- g) bicycles, except when checked as baggage with a Common Carrier;
- h) household effects and furnishings;
- i) antiques and collectors items;
- j) prosthetic limbs;
- k) prescribed medications;
- l) keys, money, credit cards (except as coverage is otherwise specifically provided herein);
- m) securities, stamps, tickets and documents (except as coverage is otherwise specifically provided herein);
- n) professional or occupational equipment or property, whether or not electronic business equipment; or

**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) \$300 per article.

A combined maximum of \$1,000 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 \$100 will be paid for the cost of replacing a passport or visa.

A maximum of \$100 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 24 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 Schedule of Benefits.

### TRIP DELAY

This Benefit is provided only if shown as covered on the Schedule of Benefits.

If an Insured is delayed for 6 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) quarantine, hijacking, strike, natural disaster, or riot;
- d) 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 \$500 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.

If the Insured is delayed by a Common Carrier while en route to their return destination after the Covered Trip is completed and has placed their cat or dog in a kennel for the duration of the Covered Trip and the Insured is unable to collect them on the day previously agreed with the kennel, benefits will be paid at \$25 per day, on a one-time basis, up to the Maximum Benefit Amount to cover the necessary additional kennel fees.

The Insured must provide the following documentation when presenting a claim for these benefits:

- a) Written confirmation of the reasons for delay from the Common Carrier whose delay resulted in the loss, including but not limited to; scheduled departure and return times and actual departure and return times;
- b) Written confirmation from the kennel advising the original pick-up date and the actual pick-up date.

Benefits will not be paid for any expenses that have been reimbursed or for any services that have been provided by the Common Carrier.

These benefits will not duplicate any benefits payable under the policy or any coverages provided herein. The Maximum Benefit Amount is shown in the Schedule 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.

**“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.

**“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.

**“Domestic Partner”** means a person who is at least eighteen 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 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 an Insured’s or a Traveling Companion’s: legal spouse or common-law spouse where legal; legal guardian; son or daughter (adopted, foster or step); child placed for adoption with the Insured or Traveling Companion; son-in-law; daughter-in-law; grandmother; grandmother-in-law; grandfather; grandfather-in-law; grandchild; aunt; uncle; niece; or nephew; brother, step-brother; sister; step-sister; brother-in-law; sister-in-law; mother; father; step- parent.

**“Hospital”** means (a) a place that operates according to law in the state where it is located; and b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility: Not included is a hospital or institution licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics: or (2) as a clinic continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

**“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 Schedule 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.

**“Pre-existing Condition”** means any injury, sickness or condition (including any condition from which death ensues) of the Insured, or Traveling Companion, or the Insured’s and/or Traveling Companion’s Family Member or the Insured’s Business Partner for which within the 180 day period prior to the effective date of the Insured’s Trip Cancellation coverage under the Policy which (a) manifested itself, became acute or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking prescribed drugs or medicine, unless the condition

for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (c) required medical treatment or treatment was recommended by a Legally Qualified Physician.

**“Published Penalties”** means any published cancellation penalties issued by the Insured’s 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 maximum amount reimbursable under the travel agencies published penalties is 10% of the total trip cost excluding taxes and other non-commissionable items.

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

**“Schedule of Coverages/Schedule”** means the coverage confirmation provided to an Insured following enrollment and payment of the applicable premium.

**“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.

**“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.

### **SECTION III. INSURING PROVISIONS**

#### **Insured’s Term of Coverage:**

**For Trip Cancellation:** Coverage begins on the Effective Date and time specified in the Schedule of Benefits. Coverage ends at the point and time of departure on an Insured’s Scheduled Departure Date.

**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 an act of declared or undeclared war;
2. while participating in maneuvers or training exercises of an armed service;
3. 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;
4. to which a contributory cause was the commission of or attempt to commit a felony or being engaged in an illegal occupation;
5. due to normal childbirth, normal pregnancy through the first 9 months of pregnancy or voluntarily induced abortion;
6. Due to a mental or nervous condition, unless hospitalized;
7. for dental treatment (except as coverage is otherwise specifically provided herein);
8. which exceed the Maximum Benefit Amount for each attached coverage as shown in the Schedule of Benefits: or;
9. due to a Pre-existing Condition, as defined in the Policy. The Pre-existing Condition Limitation does not apply to: to coverage purchased within 24 hours from the time the initial Covered Trip deposit is paid the purchase of the Insured's Covered Trip if the full cost of the Covered Trip is protected and if the Insured is medically able to travel when payment is made for the insurance and has not filed a claim for Trip Cancellation due to a pre-existing condition within 180 days of their Effective Date..
10. due to loss or damage (including death or injury) and any associated cost or expense resulting directly from the discharge, explosion or use of any device, weapon or material employing or involving chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act and regardless of any other sequence thereto.

**The following limitation applies to Trip Cancellation:** All cancellations must be reported directly to the Travel Supplier within 72 hours of the event causing the need to cancel, unless the event prevents it, and then as soon as is reasonably possible. If the cancellation is not reported within the specified 72-hour period, the Company will not pay for additional charges which would not have been incurred had an Insured notified the Travel Supplier in the specified period. If the event prevents an Insured from reporting the cancellation, the 72-hour notice requirement does not apply; however, an Insured must, if requested, provide proof that said event prevented him or her from reporting the cancellation within the specified period.

#### **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 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 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.

**Excess Insurance:** The insurance provided by this Certificate shall be in excess of all other valid and collectible Insurance or indemnity. If at the time of the occurrence of any loss there is other valid and collectible insurance or indemnity in place, the Company shall be liable only for the excess of the amount of loss, over the amount of such other insurance or indemnity, and applicable deductible. Recovery of losses from other parties does not result in a refund of premium paid.

**Proof of Loss:** Proof of loss must be provided within 90 days after the date of the loss or as soon as is reasonably possible. Proof must, however, be furnished no later than 12 months from the time it is otherwise required, 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 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 \$1,000.00 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 60 days after we receive proof of loss. No legal action for a claim can be brought against us more than 3 years after the time required for giving proof of loss. This 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.

**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 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. GRIEVANCE PROCEDURES**

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

#### **DEFINITIONS**

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

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

### **INFORMAL GRIEVANCE PROCEDURE**

If you have a complaint about a claim denial, you, your authorized representative, or a provider acting on your behalf may call our Customer Services department at 1-866-887-7148 to informally resolve your complaint. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to further explain the issue or immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5- business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 15-days after receiving the complaint and all necessary information.

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

### **FORMAL GRIEVANCE PROCEDURE**

In the event of an Adverse Determination, you, your authorized representative, or a provider acting on your behalf may submit a formal Grievance within 180-days following receipt of the Adverse Determination.

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.

In the event you fail to submit all information needed to decide the appeal. We will notify you in writing of precisely what is required. You will have 45-days within which to respond to our request and provide sufficient information. If you fail to provide the necessary information within that timeframe, we may deny the appeal on the basis of incompleteness.

### **Internal First Level Review**

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

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 30-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 Internal First Level Review process.
- (2) A statement of the reviewer's understanding of the Grievance.
- (3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
- (4) A reference to the evidence or documentation used as the basis for the decision.
- (5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
- (6) A statement advising you of your right to request an External Second Level Review, if applicable, and a description of the procedure and timeframes for requesting an External Second Level Review and options for bringing a legal action.

## **External Second Level Review**

The External Second Level Review process is available if you are not satisfied with the outcome of the Internal First Level Review for an Adverse Determination or if you have requested an Informal or Internal First Level Review and did not receive a decision from the Company within the time frames allowed for such reviews. Within 10-business days after receiving a request for an External Second Level Review, we or our designated utilization review organization will provide you and the selected independent review organization with the following:

- (1) The name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
- (2) A statement of your rights, including the right to:
  - Attend the External Second Level Review;
  - Present his/her case to the review panel;
  - Submit supporting materials before and at the review meeting;
  - Ask questions of any member of the review panel;
  - Be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney;
  - Request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination;
- (3) A copy of your health insurance contract, evidence of coverage, benefit summary, or similar document;
- (4) All relevant medical records;
- (5) A summary of the applicable issues, including a statement of our final determination;
- (6) The clinical review criteria used and the clinical reasons for the determination;
- (7) Any communications between you and us regarding the Informal or Internal First Level Review; and
- (8) All other documents, information, or criteria relied upon by us in making our determination.

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

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

The panel must be comprised of persons who:

- (1) Were not previously involved in any matter giving rise to the External 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 an External Second Level Grievance involving a Utilization Review non-certification or a clinical issue must be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on an Internal First Level Review, we may use one of our employees on the External Second Level Review panel if the panel is comprised of 3 or more persons.

A written statement of the External Second Level Review panel's decision will be issued to you and, if applicable, to your representative or provider, within 10-business days after completing the review meeting. The decision will 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, Internal First Level Review or External Second Level Review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

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

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 review of Adverse Determination

**You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to read your policy carefully, or contact your local U.S. Department of Labor Office, or the New Hampshire Insurance Department.**

**The New Hampshire Insurance Department is available to assist you with insurance related problems and questions. You may inquire:**

**By writing to: NH Insurance Department  
21 South Fruit Street  
Concord, NH 03301-7317**

**By telephone: 603-271-2261, direct or  
toll-free at 1-800-852-3416**