UATP Accountholder Coverage – Domestic

Confirmation of Benefits
As an eligible UATP Accountholder[1], you are automatically protected for the following, provided the entire cost of the scheduled airfare(s), less redeemable certificates, vouchers or coupons, has been charged to a UATP Account[2]:

Benefits	Maximum Benefit Limit
Accidental Death & Dismemberment Common Carrier Only	$125,000
Baggage Delay	$500

[1] Accountholder means an individual whose ticket is charged to a valid UATP Account.
[2] Account means charge card Accounts sponsored by UATP and provided by UATP Issuers to corporate subscribers domiciled within the USA, Canada and Puerto Rico.

UNITED STATES FIRE INSURANCE COMPANY
Administrative Office: 5 Christopher Way,
Eatontown, New Jersey 07724
(Called "the Company")

INDIVIDUAL TRAVEL PROTECTION POLICY

THIS IS A LIMITED BENEFIT, SHORT-TERM TRAVEL POLICY

This is a legal contract between United States Fire Insurance Company and You. This Policy is issued in consideration of the Application and payment of the appropriate plan cost. United States Fire Insurance Company, herein called the Company, will pay You the benefits described in this Policy, subject to all Policy limitation, and exclusions, when You sustain a loss specified under a provision of the Policy under which You are covered, as shown in the Confirmation of Benefits and Evidence of Benefits. The entire contract is made up of the Policy and any attachments. No agent may change it in any way. Only an officer of the Company can approve a change. Any such change must be shown in the Policy or its attachments.

Signed for the Company,

Chairman and CEO,

Marc J. Adee

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SECTION I. PERIOD OF COVERAGE

The "Effective Date" of Your Travel Protection Policy begins at 12:01 a.m. following the postmark of Your application or 12:01 a.m. following the date You apply by phone or fax and pay the required plan cost. The Trip Cancellation Benefit begins on the Effective Date. The Trip Delay Benefit is in force while You are en route to and from Your Trip. All other Benefits begin on 12:01 a.m. on the later of Your Scheduled Departure Date or the Effective Date of Your Travel Protection Policy, as described above. Benefits end for all Insureds when You cancel Your Trip, when You return home, or when You complete the term of Your Trip.

SECTION 2. 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. You or someone on Your 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.

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: benefits for loss of life are payable to You. The first individual named on the application form is the beneficiary for all other insureds. All or a portion of all other benefits provided by this Polo icy may, at the option if the Company, be paid directly to the provider of the services(s). All benefits not paid to the provider will be paid to You. Other than for loss of life, if any benefit is payable to either another Insured or Your beneficiary who is a minor or otherwise not able to give a valid release or Your estate, the Company may pay up to $1,000 to Your beneficiary or any relative to whom the Company finds entitled to the payment. Any payment made in good faith shall fully discharge the Company from obligations under this Policy to the extent of such payment.

Payment of Claims: All benefits are payable to You, if alive. Otherwise benefits are payable to Your estate.

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 intentionally concealed or misrepresented.

Other Insurance with the Company: An Insured may be covered under only one travel policy with the Company for each 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.

Clerical Error: Clerical error on the Company's part or that of a Travel Supplier in keeping records or furnishing information will not void an Insured's coverage if it is otherwise validly in force; nor will it continue an Insured's coverage if it is otherwise validly terminated under the terms of this Policy.

Conformity with State Statutes: The provisions of this Policy must conform with the laws of the state in which the Policy is issued. If any do not, they are hereby amended to conform.

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. You are entitled to complete reimbursement for loss covered under this Policy before the Company is entitled to subrogation proceeds.

SECTION 3. POST DEPARTURE PROTECTION PLAN

EVIDENCE OF BENEFITS

The following Benefits are provided under Your Policy as shown in Your Schedule of Benefits. Each Benefit is to all policy provisions not in conflict with the provisions of the particular Benefit provided.

24-HOUR ACCIDENTAL DEATH AND DISMEMBERMENT

PART A BENEFITS

When an Insured sustains covered injuries resulting in any of the following losses within 365-days from the date of the Accident, benefits will be paid as follows:

Loss of Life . . . . . .Principal Sum
Loss of Both Feet, Both Hands or Both Eyes.....Principal Sum
Loss of One Hand and One Foot. . . . . ..Principal Sum
Loss of One Hand and One Eye or One Foot and One Eye..... . . Principal Sum
Loss of One Hand, One Foot or One Eye.....One-half Principal Sum

The Principal Sum is shown in the Schedule of Benefits.

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 coverage(s) attached to the Policy.

PART B EXPOSURE AND DISAPPEARANCE

If, while insured under this Benefit, an Insured is unavoidably exposed to the elements because of a covered Accident and suffers a loss for which benefits are payable under this Benefit, such loss will be covered.

If, while insured under this Benefit, an Insured is in an Accident resulting in the disappearance, sinking or damaging of an air or water conveyance on which he or she is covered by this Benefit, and if his or her body has not been found within 52

weeks from the date of the Accident, it will be presumed, unless there is evidence to the contrary, that he or she suffered loss of life as a result of those Injuries.

BAGGAGE AND PERSONAL EFFECTS
The Maximum Benefit Amount is shown in the Schedule of Benefits.

PART A DEFINITIONS
"Baggage and Personal Effects" means goods being used by an Insured during a 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) sunglasses, contact lenses, artificial teeth, dental bridges or hearing aids;
k) prosthetic limbs;
l) prescribed medications;
m) keys, money, credit cards, tickets, documents or securities, (except as coverage is otherwise specified under the Policy), stamps;
n) professional or occupational equipment or property, whether or not electronic business equipment; or
o) telephones, computer hardware or software.

PART B BENEFITS

For Baggage Delay: If, while on a 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 Your 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.

PART C CONDITIONS
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 covered under any other insurance.

These benefits will not duplicate any benefits payable under the Policy or any coverage(s) attached to the Policy.

PART D
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.

PART E ADDITIONAL CLAIMS PROVISIONS SPECIFIC TO BAGGAGE
Your Duties After Delay of Baggage: In case of loss, theft, damage or delay of baggage or personal effects, and You 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 Trip.

No Benefit to Bailee: This insurance shall not benefit any Common Carrier or bailee.

GENERAL LIMITATIONS AND EXCLUSIONS FOR ALL BENEFITS

Benefits are not payable for Sickness, Injuries or losses of You, Your Traveling Companion, You or Your Traveling Companion's Family Member, or Your 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;
5. while mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment);
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 or deep sea diving;
8. while piloting or learning to pilot or acting as a member of the crew of any aircraft;
9. for **Accidental Death and Dismemberment** benefits; due to alcoholism and drug addiction;
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. due to a Pre-existing Condition, as defined in this Policy. The Pre-existing Condition Limitation;
14. for mental or nervous disorders, unless hospitalized; or

DEFINITIONS FOR ALL BENEFITS

"Accident" means a sudden, unexpected, or unintended event that occurs while this Policy is in force and causes Injury.

"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 is: (a) involved in a legal general partnership with You; or (b) is actively involved in the day-to-day management of Your business.

"Common Carrier" means any public land, sea or air conveyance operating under a valid license providing for the transportation of passengers for hire.

"Default" means a material failure or inability to provide contracted services.

"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 Trip, reduced by the value of an unused return travel ticket.

"Family Member" means any of the following who resides in the United States, Canada or Mexico: You or Your 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.

"Hospital" means (a) a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located: (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: (c) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals. 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.

"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 after the Effective Date and prior to the Insured's scheduled return date; and (b) resulting in loss independently of sickness and all other causes and certified by a Legally Qualified Physician.

"Insured" means the Principal Insured and his or her Family Members, Business Partner, or Traveling Companion who are covered under the Principal Insured's Policy.

"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 (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 each coverage described herein and 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 ensures of You, or Your Traveling Companion, or Your and/or Your Traveling Companion's Family Member or Your Business Partner scheduled or booked to travel with You which within the one hundred eighty (180) day period prior to the effective date of the Insured's coverage under this 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.

"Principal Insured" means the individual named on the application who has purchased a Trip and who has paid the required cost for the Policy. You and Yours refer to the Principal Insured.

"Scheduled Departure Date" means the date on which You are originally scheduled to leave on the Trip.

"Scheduled Return Date" means the date on which You are originally scheduled to return to the point of origin or the original final destination.

"Schedule of Benefits" means the coverage confirmation provided to You following application and payment of the applicable premium.

"Sickness" means an illness or disease that is first manifested, diagnosed or treated by a Legally Qualified Physician after the effective date of insurance and while the Insured is covered under this 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 Trip.

"Traveling Companion" means a person or persons with whom a covered person has coordinated travel arrangements and intends to travel with during the trip.

"Travel Supplier" means any entity or organization that coordinates or supplies Your travel services for You.

"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.

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

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
Fairmont Specialty
5 Christopher Way, 3rd Floor
Eatontown, New Jersey 07724

When used throughout this document “Company”, “Our”, “We”, or “Us” means:
United States Fire Insurance Company

GRIEVANCE PROCEDURES

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

DEFINITIONS

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

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

INFORMAL GRIEVANCE PROCEDURE

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

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

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

FORMAL GRIEVANCE PROCEDURE

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

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

First Level Review

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

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

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

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

(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

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

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

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

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

The panel must be comprised of persons who:

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

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

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

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

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

EXPEDITED REVIEW

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

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-

hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.
We will not provide an expedited review for retrospective reviews of Adverse Determinations.

Summary of Provisions

This insurance is effective May 1, 2011 and will cease on the date the Certificate Policy Number US043223D is terminated or on the date your Account ceases to be in good standing, whichever occurs first.

Coverage does not apply while acting or training as a pilot or crew member or while dead-heading (member of an airline's flight staff carried free of charge while not working on that specific flight).

Certificate Policy Number: US043223D

For additional information about the plan or to make a claim, please contact the Plan Administrator.

This plan was designed for UATP Accountholders by Aon Affinity.

Aon Affinity is the brand name for the brokerage and program administration operations of Affinity Insurance Services, Inc. (TX 13695); (AR 100106022); in CA & MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services, Inc.; in CA, Aon Affinity Insurance Services, Inc. (CA 0G94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY, AIS Affinity Insurance Agency.

Affinity Insurance Services is acting as a Managing General Agent as that term is defined in section 626.015(14) of the Florida Insurance Code. As an MGA we are acting on behalf of our carrier partner.

Participating Organization:
Universal Air Travel Plan, Inc.
1425 K Street, Suite 700
Washington, DC 20005 USA

Plan Administrator:
Aon Affinity
1100 Virginia Drive, Suite 250
Ft. Washington, PA 19034

For IATAN ID Cardholders Residing In The United States Underwritten by:
United States Fire Insurance Company
Administrative Office: 5 Christopher Way,
Eatontown, NJ 07724
(Hereinafter referred to as "the Company")