



Life Insurance Company of North America  
1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235

**IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED**

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about fixed payment benefits. This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

Your Benefit Summary provides a very brief description of the important features of the coverage being considered. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both the master policyholder and Life Insurance Company of North America.

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

**CAUTION:** If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), you should check with your tax advisor or benefit advisor prior to purchasing this coverage to be sure that you will continue to be eligible to contribute to the HSA if this coverage is purchased. Please refer to your Benefit Summary for more information, including a listing of the policy exclusions, limitations, and reductions that may affect benefits payable under the Critical Illness Insurance plan.

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**Employee-Paid**  
**ACCIDENTAL INJURY INSURANCE**

**SUMMARY OF BENEFITS**

Prepared for: The Western Union

Accidental Injury coverage provides a fixed cash benefit according to the schedule below when a Covered Person suffers certain Injuries or undergoes a broad range of medical treatments or care resulting from a Covered Accident. See State Variations (marked by \*) below.

**Who Can Elect Coverage:**

**You:** All active, full-time and part-time Employees of the Employer who reside in WA and are regularly working a minimum of 15 hours per week, who are United States citizens and permanent resident aliens, regularly working in the United States. Excluding Non-WA residents and Non-U.S. citizens.

You will be eligible for coverage the first of the month following date of hire.

**Your Spouse\*:** Up to age 70, as long as you apply for and are approved for coverage yourself.

**Your Child(ren):** Birth to age 26, as long as you apply for and are approved for coverage yourself.

**Available Coverage:** This Accidental Injury plan provides 24 hour coverage.

The benefit amounts shown in this summary will be paid regardless of the actual expenses incurred and are paid on a per day basis unless otherwise specified. Benefits are only payable when all policy terms and conditions are met. Please read all the information in this summary to understand terms, conditions, state variations, exclusions and limitations applicable to these benefits. See your Certificate of Insurance for more information.

Benefit Percentage Amount (unless otherwise indicated)	Employee	Spouse	Children
	100% of benefits shown	100% of benefits shown	100% of benefits shown

Initial & Emergency Care	Plan 1	Plan 2
Emergency Care Treatment	\$150	\$300
Physician Office Visit	\$75	\$150
Diagnostic Exam (x-ray or lab)	\$10	\$50
Ground or Water Ambulance/Air Ambulance	\$300/\$1,200	\$400/\$1,600
Hospitalization Benefits	Plan 1	Plan 2
Hospital Admission	\$500	\$1,000
Hospital Stay	\$100	\$200

Hospitalization Benefits	Plan 1	Plan 2
Intensive Care Unit Stay	\$200	\$400
Fractures and Dislocations	Plan 1	Plan 2
Per covered surgically-repaired fracture	\$100-\$4,000	\$200-\$8,000
Per covered non-surgically-repaired fracture	\$50-\$2,000	\$100-\$4,000
Chip Fracture (percent of fracture benefit)	25%	25%
Per covered surgically-repaired dislocation	\$100-\$4,000	\$200-\$6,000
Per covered non-surgically-repaired dislocation	\$50-\$2,000	\$100-\$3,000
Follow-Up Care	Plan 1	Plan 2
Follow-up Physician Office Visit	\$50	\$75
Follow-up Physical Therapy Visit	\$25	\$50
Enhanced Accident Benefits	Plan 1	Plan 2
Examples:		
Small Lacerations (Less than or equal to 6 inches long and requires 2 or more sutures)	\$50	\$100
Large Lacerations (more than 6 inches long and requires 2 or more sutures)	\$400	\$600
Concussion	\$100	\$150
Coma (lasting 7 days with no response)	\$5,000	\$10,000

*Additional Accidental Injury benefits included - See certificate for details, including limitations & exclusions. Virtual Care accepted for Initial Physician Office Visit and Follow-Up Care.*

### Employee's Semi-Monthly Cost of Coverage:

Tier	Plan 1	Plan 2
Employee	\$3.17	\$6.14
Employee and spouse	\$5.41	\$10.47
Employee and child(ren)	\$5.50	\$10.65
Family	\$7.41	\$14.38

*Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.*

### Important Definitions and Policy Provisions:

**Coverage Type:** Benefits are paid when a Covered Injury results, directly and independently of all other causes, from a Covered Accident.

**Covered Accident:** A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and occurs while the Covered Person is insured under this Policy; is not contributed to by disease, sickness, mental or bodily infirmity; and is not otherwise excluded under the terms of this Policy.

**Covered Injury:** Any bodily harm that results directly and independently of all other causes from a Covered Accident.

**Covered Person:** An eligible person who is enrolled for coverage under this Policy.

**Covered Loss:** A loss that is the result, directly and independently of other causes, from a Covered Accident suffered by the Covered Person within the applicable time period described in the Policy.

**Hospital:** An institution that is licensed as a hospital pursuant to applicable law; primarily and continuously engaged in providing medical care and treatment to sick and injured persons; managed under the supervision of a staff of medical doctors; provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and has medical, diagnostic and treatment facilities with major surgical facilities on its premises, or available to it on a prearranged basis, and charges for its services. The term Hospital does not include a clinic, facility, or unit of a Hospital for: rehabilitation, convalescent, custodial, educational, or nursing care; the aged, treatment of drug or alcohol addiction.

**When your coverage begins:** Coverage begins on the later of the program's effective date, the date you become eligible, or the first of the month following the date your completed enrollment form is received unless otherwise agreed upon by Cigna. Your coverage will not begin unless you are actively at work on the effective date. Coverage for all Covered Persons will not begin on the effective date if hospital, facility or home confined, disabled or receiving disability benefits or unable to perform activities of daily living.

**When your coverage ends:** Coverage ends on the earliest of the date you and your dependents are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your dependent, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued. Be sure to read the provisions in your Certificate.)

**30 Day Right To Examine Certificate:** If a Covered Person is not satisfied with the Certificate for any reason, it may be returned to us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

**Benefit Conditions and Limitations:** This document provides only the highlights. All claims for a covered loss must meet specific Benefit Conditions and Limitations and are otherwise subject to all other terms set forth in the group policy.

**Common Exclusions:\*** In addition to any benefit specific exclusions, no payments will be made for losses which directly or indirectly, is caused by or results from: • intentionally self-inflicted injury, including suicide or any attempted suicide; • committing an assault or felony; • bungee jumping; parachuting; skydiving; parasailing; hang-gliding; • declared or undeclared war or act of war; • Aircraft or air travel, except as a commercial passenger or Aircraft used by the Air Mobility Command (unless owned, leased or controlled by policy holder/subscriber); • sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, except bacterial infection from an accidental external cut or wound or accidental ingestion of contaminated food; • activities of active military duty, except Reserve or National Guard active duty training lasting 31 days or less; • services or treatment rendered by a physician, nurse or any other person who is: employed by the subscriber, living with or immediate family of the Covered Person, or providing alternative medical treatments. Actual policy terms may vary depending on your plan design and location.

**Specific Benefit Exclusions & Limitations:\***

**Emergency Care Treatment:** Treatment must occur within 30 days of the Covered Accident. Limits: payable once per Covered Accident, per Covered Person. Excludes: treatment provided by an immediate family member, clinic, or doctor's office. **Physician Office Visit:** Must be diagnosed and treated by a physician within 365 days of the Covered Accident. Limits: payable once per Covered Accident, per Covered Person; not payable if a Covered Person is eligible to receive a benefit under Emergency Treatment. Excludes: routine health examinations or immunizations for Covered Persons Age 60 and older, visits for mental or nervous disorders, and visits by a surgeon while confined to a Hospital. **Diagnostic Exam:** payable once per Covered Accident, per Covered Person. Treatment must occur within 365 days of the Covered Accident. **Ground or Water Ambulance/Air Ambulance:** Services must be provided from the scene of the Covered Accident or within 365 days of Covered Accident. Limits: payable once per Covered Accident, per Covered Person, only one benefit will be paid ground or water/air, whichever is greater. **Hospital Admission:** Inpatient admission must occur within 365 days of the Covered Accident due to such accident. Limits: payable once per Covered Accident. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Accident. **Hospital Stay per day:** Must be admitted for at least 23 hours or admitted inpatient and confined within 365 days of the Covered Accident. Limits: 365 days per Covered Accident; 1 stay accident, not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 365 days for the same or a related Covered Accident are considered one Stay. **Intensive Care Unit Stay per day:** Must be admitted for at least 23 hours or admitted inpatient and confined within 365 days of the Covered Accident. Limits: 365 days per Covered Accident, not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 365 days for the same or a related Covered Accident are considered one Stay. **Fracture/Dislocation:** If more than one fracture, only one benefit will be paid, whichever is the greater amount. Chip fracture not paid in addition to closed fracture. Limits: Both fractures and dislocations are limited to 1 per accident. Must be diagnosed and treated by a physician within 365 days of the Covered Accident. **Follow-up Physician Office Visit:** Limits: 10 follow up visit(s) for each Covered Person per Covered Accident for follow up physician office visits. Must be examined, treated or prescribed by physician. Examination or treatment must be provided within 90 days and treatment must be completed within 365 days of the Covered Accident. **Follow-up Physical Therapy Visit:** Limits: 10 follow up visit(s) for each Covered Person per Covered Accident for follow up physical therapy visits. Must be examined, treated or prescribed by physician. Examination or treatment must be provided within 90 days and treatment must be completed within 365 days of the Covered Accident. **Large Lacerations:** Treatment by physician must be received within 365 days of the Covered Accident. Limits: payable 1 time per Covered Person, Per Covered Accident; Multiple lacerations pay a maximum of 2 times the benefit. **Concussion:** Must be diagnosed by a physician within 365 days of the Covered Accident. Limits: payable 1 time per Covered Accident. **Coma:** Limits: payable 1 times per Covered Accident. Must be unconscious for 7 days or more with no response to external stimuli and requiring artificial respiratory or life support. Excludes: medically induced coma.

**\*State Variations**

For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Spouse definition includes civil union partners in New Hampshire and Vermont. **Specific Benefit Exclusions and Limitations:** The timeframe to obtain services following a covered accident is extended in SD and WA. **Common Exclusions** may vary for residents of MN, SC, SD, and WA. **Hospital/ICU Stay** requires a 31 day minimum for Idaho residents. See your Certificate for detail.

**THIS POLICY PAYS LIMITED BENEFITS ONLY. IT DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT A MEDICAID OR MEDICARE SUPPLEMENT POLICY.**

Terms and conditions of coverage for Accidental Insurance are set forth in Group Policy No. AI960496. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Please see your Plan Sponsor to obtain a copy of the Group Policy. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence. Product availability, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form GAI-00-1000.00. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192

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