SECTION III: INCOME PROTECTION BENEFITS

	Class I	Class II
III.A. WEEKLY TOTAL DISABILITY BENEFITS		
III.A.i. COVERED INJURY MINIMUM WEEKLY TOTAL DISABILITY BENEFIT		
Minimum Weekly Benefit Amount	$100	$100
Maximum Benefit Period	10 Years	10 Years
III.A.ii. COVERED ILLNESS MINIMUM WEEKLY TOTAL DISABILITY BENEFIT		
Minimum Weekly Benefit Amount	$100	$100
Maximum Benefit Period	10 Years	10 Years
III.A.iii. COVERED INJURY WEEKLY EARNED INCOME REPLACEMENT BENEFIT		
Maximum Weekly Benefit Amount	$900	$900
Maximum Benefit Period	10 Years	10 Years
III.A.iv. COVERED ILLNESS WEEKLY EARNED INCOME REPLACEMENT BENEFIT		
Maximum Weekly Benefit	$900	$900
Maximum Benefit Period	10 Years	10 Years
III.B. PARTIAL DISABILITY BENEFIT		
Maximum Weekly Benefit	$1,000	$1,000
Maximum Benefit Period	2 Years	2 Years
III.C. COST OF LIVING ADJUSTMENT		
Maximum Benefit Amount	$3,000	$3,000
III.D. FIRST WEEK TOTAL DISABILITY BENEFIT		
Maximum Benefit Amount	Weekly Earned Income up to $1,000	Weekly Earned Income up to $1,000
III.E. TRANSITION BENEFIT		
Benefit Amount	$1,000	$1,000
Maximum Benefit Period	26 Weeks	26 Weeks
III.F. RETRAINING BENEFIT		
Maximum Benefit Amount	$20,000	$20,000
III.G. WEEKLY PERMANENT PHYSICAL IMPAIRMENT BENEFIT		
Benefit Amount	Up to $1,000	Up to $1,000
Maximum Benefit Period	Lifetime	Lifetime
Benefit Amount - Illness	Up to $1,000	Up to $1,000
Maximum Benefit Period - Illness	Lifetime	Lifetime

SECTION IV: MEDICAL EXPENSE BENEFITS

IV.A. EXCESS MEDICAL EXPENSE BENEFIT

Any benefits limits apply, unless otherwise specified, on a per Insured Person per Covered Injury or Covered Illness basis.

Medical Expense Benefit selection:

Primary Medical Expense other than Workers' Compensation or No-Fault Auto Insurance

	Class I	Class II
Maximum Benefit Amount	$10,000	$10,000

IV.B. PLASTIC SURGERY EXPENSE BENEFIT

Maximum Benefit Amount	An additional 25% of the Maximum Medical Expense Benefit Amount for Covered Injury but not less than $25,000	An additional 25% of the Maximum Medical Expense Benefit Amount for Covered Injury but not less than $25,000

IV.C. HOME HEALTH CARE EXPENSE BENEFIT

Maximum Benefit Amount	$15,000	$15,000
Minimum Hospital Stay	15 Days	15 Days
Home Health Care must begin within	18 Months	18 Months

SECTION V: ADDITIONAL BENEFITS

	Class I	Class II
V.A. DAILY HOSPITAL CONFINEMENT AND OUTPATIENT TREATMENT BENEFIT		
Daily Benefit Amount	$50	$50
Maximum Benefit Period for Hospital confinement	730 days	730 days
Maximum Benefit Period for treatment after discharge	730 days	730 days
Maximum Benefit Period for treatment without Hospital confinement	365 days	365 days
V.B. DAILY CRITICAL CARE BENEFIT		
Daily Benefit Amount	$100	$100
Maximum Benefit Period	730 days	730 days
V.C. FAMILY EXPENSE BENEFIT		
Maximum Benefit Amount	$15,000	$15,000
V.D. OCCUPATIONAL REHABILITATION BENEFIT		
Maximum Benefit Amount	$20,000	$20,000
V.E. MENTAL STRESS MANAGEMENT BENEFIT		
Maximum Benefit Amount	$25,000	$25,000
V.F. TRAUMATIC INCIDENT BENEFIT		
Aggregate Maximum Benefit Amount	$25,000	$25,000
Expenses must be incurred within	12 Months	12 Months

DEFINITIONS

Appropriate Care means the determination of an accurate and medically supported diagnosis of the Insured Person's Total or Partial Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of the Total or Partial Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Auxiliary Member means any person who is a member of the auxiliary to the Participating Organizations at the time of Covered Injury or Covered Illness.

Benefit Period means the period, shown on the *Policy Schedule of Benefits,* commencing with the date of the onset of the Total Disability or Partial Disability during which benefits are payable.

Career Personnel means employees or members of the organization that receive Weekly Earned Income for regularly working at least 30 cumulative hours per week as an emergency service provider for the Participating Organizations.

Child Care Expense means the actual incurred costs for the care and supervision of an Insured Person's Dependent Child who is less than age 13.

Community Volunteer means a non-member who helps the Participating Organizations and/or the auxiliary of the organization, in a non-emergency capacity such as fund raisers, banquets, etc.

Cosmetic Disfigurement from Burns means a cosmetic disfigurement that is due to a burn that is classified as a third degree or full-thickness burn caused by a source that is thermal, chemical, electrical, or nuclear. The surface area must be documented by a Physician according to the Rule of Nines or the Lund-Browder chart.

Covered Activity means any activity which is normal for an Insured Person while acting on behalf of the Participating Organizations and includes travel directly to and from such activity, as well as impromptu action (Good Samaritan) at the scene of an emergency regardless of the Participating Organizations' involvement. Covered Activity includes all athletic events sponsored by the Participating Organizations with the exception of Organized League Athletic Events, unless such coverage is purchased.

The Covered Activity must be performed at the direction, or with knowledge, of an officer of the Participating Organizations, unless immediate action is required of the Insured Person at the scene of an emergency not on behalf of the Participating Organizations or any other organization.

Covered Illness means any disease, sickness or infection, other than those related to psychiatric illness or mental stress, contracted or suffered by an Insured Person during or resulting from a Covered Activity while this Policy is in force except as recognized by the Mental Stress Management Benefit.

Covered Illness Death means any Covered Illness, other than those related to psychiatric illness or mental stress, contracted or suffered by an Insured Person during or resulting from a Covered Activity while this Policy is in force which results in the death of an Insured Person.

Covered Injury means Accidental bodily injury sustained by the Insured Person during and/or resulting directly from an Insured Person's participation in a Covered Activity while coverage under the Policy is in force (independent of sickness, disease, mental incapacity or any other cause) and which is not otherwise defined as a Covered Illness.

Covered Injury does not include conditions caused by repetitive motion injuries or cumulative trauma not a result of an Accident, including, but not limited to: Osgood-Schlatter's Disease; bursitis; Chondromalacia; shin splints; stress fractures; tendinitis; and Carpal Tunnel Syndrome.

Covered Injury Death means a Covered Injury sustained by an Insured Person during and/or resulting directly from a Covered Activity while this Policy is in force, and which results in the death of an Insured Person.

Covered Medical Expenses means the Reasonable and Customary Charges for any of the following services: medical or surgical treatment, preventative inoculation, Hospital confinement, Home Health Care, nursing services prescribed and monitored by a Physician, Post Exposure Prophylaxis protocol (PEP) treatment, when such treatment is advised by the attending Physician, Infectious Disease screening test(s), or post exposure preventive inoculations as a result of participation in a Covered Activity.

Criminal Assault means any willful or unlawful use of force upon an Insured Person:

1. with the intent to cause bodily injury to an Insured Person; and
2. that results in bodily harm to an Insured Person; and
3. is a criminal offense or the equivalent of a criminal offense under any country, province, territory or local statutory or common law applicable in the jurisdiction where it occurs.

Dependent Child means an Insured Person's unmarried child from the moment of birth, including a natural child, grandchild, stepchild or adopted child from the date of placement with an Insured Person. The Dependent Child must be primarily dependent upon such Insured Person for maintenance and support, and must be:

1) under the age of twenty-three (23);
2) under the age of twenty-six (26) if enrolled as a full-time student at an Institution of Higher Learning; or
3) classified as an Incapacitated Dependent Child.

Dependent Parent means the parent(s) or grandparent(s) of an Insured Person or Spouse who, at the time of a Covered Injury is receiving support and care provided by the Insured Person or Spouse as evidenced by Canadian income tax returns showing the parent or grandparent as a dependent.

Emergency Volunteer means a person physically present at the time of the emergency, and who is not responding/acting as a member of any emergency service organization, who has been specifically requested to assist by the chief, line officer or other officer in charge of the emergency.

HIV means Human Immunodeficiency Virus, a virus that infects lymphocytes and other cells bearing the CD4 marker, the initial infection of which is known as acute retro viral syndrome.

Home Health Agency means an entity engaged in arranging and providing nursing services, home health services or other therapeutic and related services. The entity must be certified by a competent governmental authority in the jurisdiction where the services are rendered.

Home Health Care means Medically Necessary services provided and billed by the Home Health Agency. Such services must be prescribed and supervised by a Physician in accordance with a medical treatment.

Hospital means a public or private institution which:

1) is licensed in accordance with the laws of the jurisdiction where it is located;
2) operates for the reception, care and treatment of sick, ailing or injured persons as inpatients;
3) provides organised facilities for diagnosis and medical or surgical treatment;
4) provides twenty-four (24 hour) nursing care;
5) has a Physician or staff of Physicians ; and
6) is not primarily a day clinic, rest or convalescent home, assisted living facility or similar establishment and is not, other than incidentally, a place for the treatment of alcoholics or drug addicts.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), legal guardians or wards, grandparent, grandchild, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, aunt, uncle, niece, or nephew.

Incapacitated Dependent Child means a child who, as a result of being mentally or physically challenged, is permanently incapable of self-support and permanently dependent on an Insured Person for support and maintenance. The incapacity must have occurred while the child was:

1) under the age of twenty-three (23); or
2) under the age of twenty-six (26) if enrolled as a full-time student at an Institution of Higher Learning.

Infectious Disease means a disease included within the list of potentially life-threatening infectious diseases, developed by the Public Health Agency of Canada.

ECONOMIC OR TRADE SANCTIONS

If any coverage or amount to which any Insured Person is entitled under this Policy is in violation of any economic or trade sanctions, controls or prohibitions of any kind applicable to the Insured under any legislation adopted at any time by the Government of Canada, including without limitation sanctions, controls or prohibitions under the United Nations Act, R.S.C., 1985, c. U-2, the Special Economic Measures Act, S.C. 1992, c. 17, the Export and Import Permits Act, R.S.C. 1985, c. E-19, the Foreign Extraterritorial Measures Act, R.S.C. 1985, c. F-29, the Freezing Assets of Corrupt Foreign Officials Act, S.C. 2011, c.10, and/or the Proceeds of Crime (Money Laundering) and Terrorist Financing Act, S.C. 2000, c.17, then this Policy shall automatically be amended to reduce or annul the Insured's entitlement to the extent necessary to comply with the applicable legislation or any similar trade or economic sanctions, laws or regulations of the United States of America, the European Union, or the United Kingdom.

BLANKET ACCIDENT INSURANCE POLICY

Underwritten by:
AXIS REINSURANCE COMPANY (CANADIAN BRANCH)

Underwriting Office:
70 York Street
Suite 1010
Toronto, Ontario M5J1S9

The Company will pay the benefits of this Policy subject to its provisions. This page and the pages that follow are part of this Policy.

AXIS Reinsurance Company (Canadian Branch) insures the members of:

Anytown, Canada Emergency Services Organization (the Policyholder)

Policy Number: **PRCO-XXXXX-XXXXXXX**

AXIS Reinsurance Company (Canadian Branch) (referred to as the Company, We, Our, or Us) will pay the benefits provided by this Policy in return for the advance payment of premium. The Company makes this promise subject to all of this Policy's provisions.

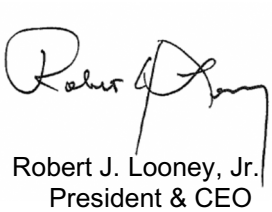
The Policy is a legal contract between the Policyholder and the Company.

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 A.M. on the Policy Effective Date at the Policyholder's address. It will remain in effect for the duration of the Policy Term if the premium is paid according to the agreed terms. This Policy terminates at 12:00 A.M., on the day following the last day of the Policy Term unless the Policyholder and the Company agree to continue coverage under this Policy for an additional Policy Term.

The Company and the Policyholder agree to all the terms of this Policy.

10 Day right to examine this Policy – The Policyholder should read this Policy carefully and contact us promptly with any questions. If the Policyholder is not satisfied for any reason, this Policy may be returned within 10 days of its receipt. We will refund any premiums already paid within 10 days after the Company receives the Policyholder's notice of cancellation of this Policy, and it will be considered never to have been issued.

The President and Secretary of the Company witness this Policy.



Robert J. Looney, Jr.
President & CEO

Brad Randell
Chief Agent for Canada

Andrew M. Weissert
Secretary

PLEASE READ THIS POLICY CAREFULLY
NON-PARTICIPATING

TABLE OF CONTENTS

POLICY SCHEDULE OF BENEFITS

Policyholder:	**Anytown, Canada Emergency Services Organization**		
Policy Number:	**PRCO-XXXXX-XXXXXXX**	**Effective Date:**	**04/01/2023**
Renewal Date:	**04/01/2026**	**Expiration Date:**	**03/31/2026**
Payment Method:	3 Year Annual Installment	**Total Premium:**	**$15,990**
Annual Anniversary Date:	April 1	**Policy Term:**	**04/01/2023 - 03/31/2026**
Rate Guarantee Period: 3 Years			
The initial premium rate guarantee and any premium rate guarantee applicable to renewal are subject to the Policy Term and Renewal and Premium Rate Change sections of this Policy.			

Premium Due Dates: Premium is due and payable in annual installments with the first installment due as of the Policy Effective Date and subsequent installments due as of each Anniversary Date	**1st Installment:**	04/01/2022	$5,330
	2nd Installment:	04/01/2023	$5,330
	3rd Installment:	04/01/2024	$5,330

Eligible Persons:		
Class I	All volunteer classes of membership including but not limited to a Volunteer Member, Emergency Volunteer, Auxiliary Member, Community Volunteer, Board Member, Trustee, Administrative Personnel, Junior Member, Member in Training, Probationary Member, and Part-Time Employees of the Policyholder.	Effective Date: 04/01/2022
Class II	All Career Personnel of the Policyholder. [or] All chief officers of the Policyholder.	Effective Date: 04/01/2022
Participating Organizations	Not Applicable	

POLICY SCHEDULE OF BENEFITS
SUMMARY OF COVERAGE

This Policy provides coverage for the following benefits that indicate that they are "Included" or that provide a specified amount opposite the name of the benefit. Benefits indicated as "Not Included" are not provided under this Policy.

SECTION I: DEATH BENEFITS

	Class I	Class II
I.A. COVERED INJURY DEATH BENEFIT		
Principal Sum	$150,000	$150,000
I.B. COVERED ILLNESS DEATH BENEFIT		
Principal Sum	$150,000	$150,000
I.C. HIV POSITIVE DIAGNOSIS LUMP SUM BENEFIT		
Benefit Amount	$150,000	$150,000
I.D. BEREAVEMENT BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
I.E. DEPENDENT CHILD BENEFIT		
Benefit Amount for each Dependent Child	$30,000	$30,000
I.F. SEATBELT AND AIRBAG BENEFIT		
Seatbelt Benefit Amount	$37,500	$37,500
Airbag Benefit Amount	$37,500	$37,500
I.G. PARENT CARE BENEFIT		
Benefit Amount per Dependent Parent	$5,000	$5,000
Maximum Benefit Amount	$40,000	$40,000
I.H. CHILD CARE EXPENSE BENEFIT		
Maximum Annual Benefit Amount per Dependent Child	$5,000	$5,000
Maximum Benefit Amount	$50,000	$50,000
I.I. IDENTIFICATION BENEFIT		
Maximum Benefit Amount	$15,000	$15,000
I.J. REPATRIATION BENEFIT		
Maximum Benefit Amount	$20,000	$20,000
I.K. MEMORIAL EXPENSE BENEFIT		
Maximum Benefit Amount	$5,000	$5,000
I.L. SURVIVING SPOUSE EDUCATION BENEFIT		
Benefit Amount	$15,000	$15,000
Maximum Benefit Period	4 Years	4 Years
I.M. DEPENDENT CHILD EDUCATION BENEFIT		
Maximum Benefit Amount per Dependent Child	$5,000	$5,000
Maximum Benefit Period	4 Years	4 Years
I.N. MILITARY DEATH BENEFIT		
Benefit Amount	$15,000	$15,000
I.O. SAFETY VEST BENEFIT		
Maximum Benefit Amount	$37,500	$37,500

Inpatient means confined overnight as a registered bed-patient in a Hospital or other medical facility where at least one day's room and board is charged. The confinement must be on the advice of a Physician.

Institution of Higher Learning means any accredited public or private college, university, professional trade or vocational school beyond the twelfth (12th) grade.

Insured Person means any person who is listed as an Eligible Person on the *Policy Schedule of Benefits*.

Loss means Accidental:

Loss of Arm
Loss of Finger
Loss of Foot
Loss of Hand
Loss of Hearing
Loss of Joint
Loss of Leg
Loss of Life
Loss of Speech
Loss of Thumb and Index Finger
Quadriplegia
Paraplegia
Hemiplegia
Brain Damage
Coma
Covered Illness
Human Immunodeficiency Virus (HIV)
Permanent Physical Impairment
Vision Impairment

Loss of Earnings Coverage means any disability benefits or salary continuance received from:

1. the benefits payable in accordance with any Workers' Compensation Act or Occupational Disease Act or Law, or any other law which provides compensation for an occupational injury;
2. the income benefit provided by or through any automobile insurance plan or any government plan of automobile insurance or similar insurance regulation or law;
3. the salary continuation or severance allowance provided by or through the employer;
4. the disability, retirement or other income benefits provided by or through the employer, the Participating Organizations, or the Insured Person; and
5. the amounts paid or payable under any group plan or insurance policy.

Loss of Earnings Coverage does not include disability benefits received from individual disability insurance paid by the Insured Person.

Medical Services means Medically Necessary services, including but not limited to:

1) medical care and treatment by a Physician;
2) Hospital room and board and Hospital care, both inpatient and outpatient;
3) drugs and medicines required and prescribed by a Physician;
4) diagnostic tests and x-rays prescribed by a Physician;
5) transportation of an Insured Person in an emergency transportation vehicle from the location where such Insured Person becomes injured to the nearest Hospital where appropriate medical treatment can be obtained;
6) preventative inoculation;
7) employment of a trained nurse;
8) dental care and treatment due to Accidental bodily injury.

Medically Necessary means medical services that: (1) are essential for diagnosis, treatment or care of the Covered Injury or Covered Illness for which it is prescribed or performed; (2) meet generally accepted standards of medical practice; and (3) are ordered by a Physician and performed under his or her care, supervision or order.

Nurse means a licensed graduate registered Nurse (R.N.) or a licensed practical Nurse (L.P.N.) who is not:
1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household; or
4. a person employed or retained by the Participating Organizations.

Organized League Athletic Event means any type of sporting event or activity that occurs during a pre-planned schedule of practices, games, matches and/or tournaments over a specific season and may include the usage of a team roster, designated uniforms, umpires/referees, or fees paid to participate.

Other Plan means any other insurance or payment source for Medical Services or disability, including but not limited to health coverage, primary disability insurance, worker's compensation insurance; or coverage provided or required by any law or statute, including, automobile insurance "fault" or "no-fault", employer sick leave or salary continuation plan, or similar benefit provided or required by governmental plan or program.

Outpatient means an Insured Person who is a patient and is not hospitalized overnight but who visits a Hospital, clinic, or associated facility for diagnosis or treatment.

Partial Disability or Partially Disabled means, for an Insured Person with an occupation producing wages as described in the definition of Weekly Earned Income, the inability to perform one or more, but not all, of the material and substantial duties of his or her own occupation as a result of a Covered Injury or Covered Illness.

If an Insured Person does not have an occupation producing wages as described in the definition of Weekly Earned Income, Partial Disability or Partially Disabled means:
1. the inability to perform one or more, but not all of the material and substantial duties of an occupation for which an Insured Person is qualified by reason of education, training or experience; or
2. the inability to perform one or more, but not all of the regular activities of an Insured Person.

An Insured Person must be under the regular care of a Physician during Partial Disability.

Permanent Physical Impairment means a physical impairment or functional abnormality of a body part or parts that, in accordance with the American Medical Association's "Guide to the Evaluation of Permanent Impairment" most current at the time of the claims, results in an impairment of the whole person and which remains after maximum medical rehabilitation has been achieved and which is considered stable, or non-progressive by a Physician.

Physician means a licensed health care provider practicing within the scope of his or her license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:
1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household;
4. a person employed or retained by the Participating Organizations; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Police Reserve Officers means all officers and reserve law enforcement members appointed by the Policyholder. Such persons have completed or are actively enrolled and participating in the training and probationary period specified by the written regulations of the Policyholder.

Policy Term means the time period defined for the Policyholder shown on the *Policy Schedule of Benefits.*

Prior Weekly Earned Income means the greater of the Insured Person's:
a. Weekly Earned Income at the time the disability starts; or
b. average Weekly Earned Income for the period of twelve (12) weeks prior to the start of disability for which a claim is made; or
c. average Weekly Earned Income for the period of one year prior to the start of disability for which a claim is made.

Professional Counsellor means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

Reasonable and Customary Charge(s) means a charge that:
1. is made for a Covered Medical Expense;
2. does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit or a cardiac care unit, does not exceed the Hospital's most common charge for semi-private room and board); and
3. does not include charges that would not have been made if no insurance existed.

Reasonable Occupation means any occupation for which an Insured Person is reasonably fitted based on education, training or experience and an Insured Person could expect to generate the lesser of $75,000 annually or at least 70% of his or her Weekly Earned Income.

Regular Occupation means the Insured Person's primary occupation at the time of disability for which he or she was receiving remuneration.

Review Date means the date after 52 weeks of continuous disability.

Safety Vest means a vest designed to enhance the visibility of the insured person.

Spouse means a person of the same or opposite sex who:
1. is legally married to and cohabits with the Insured Person, or if there is no such person,
2. is a person who qualifies as a common law or domestic partner under the provisions of any applicable provincial, territorial, or local law.

Supplemental Restraint System means any airbag that inflates upon impact for added protection to the head and chest areas.

Total Disability or Totally Disabled means that for the first 5 years from the date of a Covered Injury or onset of a Covered Illness, an Insured Person:
1. is not able to perform the substantial and material duties of his or her occupation; and
2. is receiving Appropriate Care.

After 5 years from the date of a Covered Injury or onset of a Covered Illness, Total Disability or Totally Disabled means that due to a Covered Injury or a Covered Illness an Insured Person:
1. is not able to engage in any Reasonable Occupation;
2. is not working at any other occupation; and
3. is receiving Appropriate Care.

Traumatic Incident means an abnormal experience involving the Participating Organizations, outside the range of usual human experiences and that includes: 1) line of duty death or serious injury to other Insured Persons; 2) a single incident having multiple casualties; 3) death or serious injury of a child; 4) dealing with victims known to the Insured Person; and 5) similar incidents that would reasonably require mental health care for the entire Participating Organizations or a significant number of members of the Participating Organizations.

Traumatic Incident Stress Management Team means an organized group of mental health professionals and peer support individuals trained to provide support services to emergency service organization personnel. Such support services include traumatic incident stress defusing, debriefing, demobilization, stress reduction education, spousal support, one-on-one interviews, or on-the-scene support.

Weekly Earned Income means the Insured Person's weekly earnings from all sources for regular, over-time and shift differential wages. Weekly Earned Income shall be substantiated by pay stubs, Canadian Individual Income Tax Return, other employment records, tax records and/or any other records which We may reasonably request. The Weekly Earned Income must be verified by the Insured Person's employer and/or tax records.

If the Insured Person is self-employed, We will compute Weekly Earned Income from the amount reported by the Insured Person on tax records and/or any other records We may reasonably request.

Weekly Earned Income does not include rent, royalties, investment income, passive income, estate and trust income or unearned income regardless of the Insured Person's active involvement in generating said forms of income, or any other income not derived directly from the Insured Person's occupational activities.

GENERAL EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided in the Policy:

1. declared or undeclared war or act of war;
2. suicide or any attempt at it, while sane or insane; or intentionally self-inflicted injuries while sane;
3. mental or emotional disorders, except as specifically provided for by the Traumatic Incident Benefit or the Mental Stress Management Benefit;
4. any Organized League Athletic Event, except as provided under the Policy;
5. an Insured Person being in, entering, or exiting any aircraft: owned, leased or operated by the Policyholder or Organization on the Policyholder's or Organization's behalf; or operated by an employee of the Policyholder or Organization on the Policyholder's or Organization's behalf;
6. an Insured Person riding as a passenger in, entering, or exiting any aircraft while acting or training as a pilot or crew member. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency;
7. an Insured Person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions or medical or surgical treatment thereof. This exclusion does not apply to an Insured Person's bacterial infection caused by an Accident or by Accidental consumption of a substance contaminated by bacteria. This exclusion does not apply to an Insured Person's Covered Illness;
8. an Insured Person participating in military action while in active military service with the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority; or
9. if the government of Canada has imposed any trade or economic sanctions prohibiting insurance of any Accident, or Loss; or there is any other legal prohibition against providing insurance of any Accident or Loss.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. living in the Insured Person's household; or
4. employed or retained by the Participating Organizations.

LIMITATIONS

The benefits contained in this policy are subject to the following limitations:

1. all Covered Injuries and Covered Illnesses arising from the same Covered Activity shall be treated as a single Covered Injury or Covered Illness. If the Insured Person sustained a Covered Injury and a Covered Illness from the same Covered Activity and the amount payable or benefit period for a specific benefit is different for Covered Injuries and Covered Illnesses, the Company will pay the higher amount or adhere to the longer benefit period.

2. if an Insured Person suffers a Covered Injury or Covered Illness that is payable under more than one of the following benefits, the most the Company will pay is the greater of the largest principal sum or the largest single benefit amount payable shown on the *Policy Schedule of Benefits* for any benefit for which the Insured Person qualifies:
   - Covered Injury Death Benefit;
   - Covered Illness Death Benefit;
   - HIV Positive Diagnosis Lump Sum Benefit;
   - Dismemberment, Loss of Speech or Hearing Benefit;
   - Vision Impairment Benefit;
   - Permanent Physical Impairment Benefit; or
   - Paralysis Benefit.

3. if an Insured Person is covered under more than one Policyholder's Blanket Accident Policy issued by the Company, the Company is limited to pay benefits under one such Policy elected by the Insured Person, his or her beneficiary, or his or her estate.

Maximum Payment for Multiple Losses and Multiple Benefits:

For any Benefit Amount identified as subject to this provision in the *Description of Benefits*, payment of such Benefit Amount will reduce the Principal Sum. If, subject to all the terms and conditions of this policy, an Insured Person is entitled to receive payment of multiple Benefit Amounts as the result of one (1) Accident, then the maximum We will pay for all benefits shall not exceed the Principal Sum, with the exception of Quadriplegia, Paraplegia and Hemiplegia.

For any Benefit Amount identified as not subject to this provision in the *Description of Benefits*, payment of such Benefit Amount will be in addition to any Principal Sum payable under this policy.

If an Insured Person has multiple Losses as the result of one (1) Accident, then the maximum Benefit Amount We will pay shall not exceed 100% of the Principal Sum with the exception of Quadriplegia, Paraplegia and Hemiplegia. In no event will the maximum Benefit Amount We will pay exceed 200% of the Principal Sum.

For the purposes of this provision the definition of Loss includes Brain Damage, Coma, Covered Illness, HIV Positive Lump Sum benefit, Permanent Physical Impairment.

DESCRIPTION OF BENEFITS

Section I: DEATH BENEFITS

I.A. COVERED INJURY DEATH BENEFIT
If an Insured Person sustains a Covered Injury that directly causes the Loss of Life, the Company will pay the Principal Sum shown on the *Policy Schedule of Benefits*.

I.B. COVERED ILLNESS DEATH BENEFIT
If an Insured Person suffers a Covered Illness that directly causes the Loss of Life, the Company will pay the Principal Sum shown on the *Policy Schedule of Benefits*.

I.C. HIV POSITIVE DIAGNOSIS LUMP SUM BENEFIT
If an Insured Person tests positive for HIV as a direct result of participation in a Covered Activity, the Company will pay the Benefit Amount shown on the *Policy Schedule of Benefits.*

An Insured Person may choose, as an option, to receive this benefit in lieu of the Permanent Physical Impairment Benefit, Covered Illness Death Benefit or Covered Injury Death Benefit.

If an Insured Person receives this benefit, the Covered Injury Death Benefit, Covered Illness Death Benefit, or Permanent Physical Impairment Benefit will not be applicable for the same Covered Activity.

This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.

I.D. BEREAVEMENT BENEFIT
If a Covered Injury Death Benefit or Covered Illness Death Benefit is payable under this Policy, an amount up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* will be paid. Bereavement Expenses means the reasonable out-of-pocket charges incurred for expenses directly associated with the Insured Person's Loss of Life, including but not limited to, bereavement counselling by a Professional Counsellor, travel, and other expenses of an Immediate Family Member or expenses related to funeral services for the Insured Person.

I.E. DEPENDENT CHILD BENEFIT
If a Covered Injury Death Benefit or Covered Illness Death Benefit is payable under this Policy, the Benefit Amount per Dependent Child shown on the *Policy Schedule of Benefits* will be paid. The Dependent Child Benefit is payable in addition to the Covered Injury Death Benefit or Covered Illness Death Benefit and other losses payable under this Policy.

The Benefit Amount will be paid directly to the Insured Person's beneficiary.

Payment made in this manner will release the Company from all liability to the extent of any payment made.

I.F. SEATBELT AND AIRBAG BENEFIT
If a Covered Injury Death Benefit is payable under this Policy and the Insured Person's death occurred in an Accident while he or she was wearing a properly fastened automobile seatbelt, the Company will pay the Seatbelt Benefit Amount shown on the *Policy Schedule of Benefits*. If the Seatbelt Benefit is payable, the additional Airbag Benefit Amount shown on the *Policy Schedule of Benefits* will be paid if the Insured Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag) when the Accident occurred.

I.G. PARENT CARE BENEFIT
The Company will pay the Benefit Amount per Dependent Parent shown on the *Policy Schedule of Benefits*, if a Covered Injury causes an Insured Person's covered Loss of Life. The Benefit Amount per Dependent Parent is payable in addition to any other applicable Benefit Amounts payable under this Policy.

Payments shall be paid to the natural person who incurs such expenses for the Dependent Parent. One time payment(s) will be made to each qualifying Dependent Parent or to the parent's legal guardian of the parent, up to the Maximum Benefit shown on the *Policy Schedule of Benefits*. Our total payment will not exceed the Maximum Benefit Amount for Parent Care Expense shown on the *Policy Schedule of Benefits*, regardless of the number of Dependent Parents for whom payment is made.

I.H. CHILD CARE EXPENSE BENEFIT

If a Covered Injury Death Benefit or Covered Illness Death Benefit is payable under this Policy, We will reimburse Child Care Expenses up to the Maximum Annual Benefit Amount per Dependent Child shown on the *Policy Schedule of Benefits*. The Maximum Benefit Amount is payable in addition to any other applicable Benefit Amounts payable under this policy.

This benefit applies only if the Insured Person has a Dependent Child under the age of 13 years for whom Child Care Expenses are initially incurred within 1 year of an Insured Person's covered Loss of Life.

We will reimburse Child Care Expenses for each eligible Dependent Child under the age of 13 years. However, Our total payment will not exceed the Maximum Benefit Amount shown on the *Policy Schedule of Benefits*, regardless of the number of Dependent Children under the age of 13 years for whom payment is made.

Payments shall be paid to the natural person who incurs such expenses for each Dependent Child under the age of 13 years.

I.I. IDENTIFICATION BENEFIT

If a Covered Injury Death Benefit or Covered Illness Death Benefit is payable under this Policy, and:

1. the presence of an Immediate Family Member is requested by the police or a similar governmental authority; and
2. the Loss of Life occurs not less than one hundred and fifty (150 km) kilometres from the Insured Person's city of permanent residence;

the Company will pay up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits,* subject to all applicable conditions and exclusions within one year of the Covered Activity.

The Identification Benefit is payable to the natural person who incurs the expense.

I.J. REPATRIATION BENEFIT

The Company will pay the Benefit Amount shown on the *Policy Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person suffers Loss of Life due to a Covered Injury not less than a fifty (50 km) kilometres radius from his or her current place of primary residence. The Company will pay for Covered Expenses reasonably incurred to return his or her body to his or her current place of primary residence.

Covered Expenses include expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical Conveyance and route possible; or (4) Usual and Customary Charges.

I.K. MEMORIAL BENEFIT

If a Covered Injury Death Benefit or Covered Illness Death Benefit is payable under this Policy, an amount up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* will be paid for out-of-pocket expenses actually incurred by the Policyholder for the following expenses that are directly associated with an Insured Person's Loss of Life, including but not limited to the reasonable costs associated with the memorial service, wake, honor guard, or other tribute to the Insured Person. This benefit is payable to the Participating Organizations.

I.L. SURVIVING SPOUSE EDUCATION BENEFIT

If a Covered Injury Death Benefit or Covered Illness Death Benefit is payable under this Policy, the Company will reimburse for expenses incurred by the surviving Spouse for tuition, fees, required books or supplies, room and board billed by an Institution of Higher Learning, transportation and any other costs payable directly to an Institution of Higher Learning, or approved and certified by an Institution of Higher Learning, up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits***.** These costs must be incurred by the Insured Person's Spouse to attend an Institution of Higher Learning for the purpose of obtaining or refreshing skills needed for employment. The Company shall not pay for expenses incurred by the Insured Person's Spouse for which he or she is reimbursed by another source. This benefit applies only if the surviving Spouse incurs the expense within the Maximum Benefit Period following the date of the Insured Person's covered death.

I.M. DEPENDENT CHILD EDUCATION BENEFIT
If a Covered Injury Death Benefit or Covered Illness Death Benefit is payable under this Policy, the Company will pay expenses incurred by each Dependent Child for tuition, fees, required books or supplies, room and board billed by an Institution of Higher Learning, transportation and any other costs payable directly to an Institution of Higher Learning, or approved and certified by an Institution of Higher Learning, up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits***.**

In order to qualify for benefits, a Dependent Child must:
1. be a full-time student in an accredited Institution of Higher Learning on the date of the Insured Person's death, or begin studies as a full-time student at an Institution of Higher Learning within two (2) years of the Insured Person's death and before reaching the limiting age shown in the Dependent Child definition; and
2. continue his or her education as a full-time student in such accredited Institution of Higher Learning.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian if the child is a minor, at the end of each year up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits*. The Company must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a benefit is payable will begin on the first of the month following the date the Insured Person died, if the surviving Dependent Child was a full-time student on that date in an Institution of Higher Learning; otherwise on the date he or she begins studies in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

I.N. MILITARY DEATH BENEFIT
If bodily injury sustained by the Insured Person while serving or training on behalf of the Canadian Military or respective Guard or Reserve Unit while coverage under the Policy is in force (independent of sickness, disease, mental incapacity or any other cause), results in an Insured Person's death, We will pay the Benefit Amount shown on the *Policy Schedule of Benefits*. Death must occur within 12 months of the bodily injury.

No Military Death Benefit is payable if an Covered Injury Death Benefit is payable under this policy.

I.O. SAFETY VEST BENEFIT
If a Covered Death Benefit is payable under this policy and death results from being struck as a pedestrian while on the scene of a motor vehicle accident or while directing traffic and the Insured Person was wearing a Safety Vest, We will pay an additional amount equal to the Safety Vest Benefit Amount shown in the Schedule.

Section II: IMPAIRMENT BENEFITS

II.A. DISMEMBERMENT, LOSS OF SPEECH OR HEARING BENEFIT

If an Insured Person sustains a Covered Injury that directly causes any of the Losses shown in the Table of Losses below, the Company will pay the Benefit Amount shown for the Loss. If more than one Loss results from the same Accident, the maximum amount payable is the Principal Sum. Unless provided otherwise in this Policy, these benefits will be paid in addition to any other payment for a Covered Injury or Covered Illness to which an Insured Person may be entitled under this Policy.

Loss of hand or foot means complete severance through or above the wrist or ankle. Loss of arm or leg means complete severance through or above the elbow or knee joint. Loss of thumb or index finger means actual severance through or above the metacarpophalangeal joints. Loss of second, third or fourth finger of either hand means actual severance of two or more phalanges. However, if one complete phalange but less than two phalanges is severed, the Company will pay 50% of the percentage shown for this loss shown in the Table of Losses below. Loss of speech means the entire and irrecoverable loss of the entire ability to speak. Complete loss of hearing means the entire and irrecoverable loss of the entire ability to hear in both ears. Loss of Hearing in One Ear means permanent, irrecoverable and total deafness, as determined by a Physician, with an auditory threshold of more than 90 decibels in that ear that cannot be corrected by any aid or device, as determined by a Physician.

When medical expenses are incurred in an effort to prevent one of these Losses, the amount payable for such Loss may be used for such medical expenses if the Maximum Medical Expense Benefit Amount shown on the *Policy Schedule of Benefits* has been paid. Any benefits paid for medical expenses in excess of the Maximum Medical Expense Benefit Amount will be deducted from the benefits payable under this benefit if the medical treatment fails to prevent the specific Loss.

Table of Losses

Loss	Benefit Amount
Loss of Both Hands or Both Feet	100% of the Principal Sum
Loss of One Hand and One Foot	100% of the Principal Sum
Complete Loss of Speech	100% of the Principal Sum
Complete Loss of Hearing in Both Ears	100% of the Principal Sum
Loss of One Arm or One Leg	75% of the Principal Sum
Loss of One Hand	50% of the Principal Sum
Loss of One Foot	50% of the Principal Sum
Loss of Hearing in One Ear	67% of the Principal Sum
Loss of Thumb or Index Finger of Either Hand	25% of the Principal Sum
Loss of Second, Third or Fourth Finger of Either Hand	12.5% of the Principal Sum
Loss of any Joint on Either Finger or Toe	6.25% of the Principal Sum

This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.

II.B. VISION IMPAIRMENT BENEFIT

If an Insured Person suffers a vision impairment due to a Covered Injury or Covered Illness, the Company will pay a Vision Impairment Benefit for each impaired eye. The amount of the Vision Impairment Benefit for each eye shall be the product of the Percentage of the Principal Sum corresponding to the Degree of Vision Impairment as shown below, multiplied by the Principal Sum shown on the *Policy Schedule of Benefits*.

If an Insured Person's sight was less than 20/20 before the Covered Injury or Covered Illness the Company will measure the vision impairment based upon the additional impairment measured after the Covered Injury or Covered Illness. Loss of Sight means the permanent, irrecoverable loss of the entire sight in that eye.

Vision Impairment Chart

Degree of Vision Impairment	Percentage of Principal Sum Payable for Each Eye
20/20	0.00%
20/30	2.75%
20/40	5.50%
20/50	8.25%
20/60	11.00%
20/80	16.50%
20/100	22.00%
20/120	28.00%
20/150	36.00%
20/180	45.50%
20/200 or worse	50.00%
Loss of Sight of Both Eyes (20/200 or worse in both eyes)	100%
Loss of Sight of One Eye (20/200 or worse)	50.00%

This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.

II.C. COSMETIC DISFIGUREMENT FROM BURNS BENEFIT

If an Insured Person suffers Cosmetic Disfigurement from Burns as a result of a Covered Injury, the Company will pay a benefit payable based on the following formula:

1. determination of the Area Classification Factor for the burned area as set forth in the Cosmetic Burns Schedule as shown below;
2. the Area Classification Factor is multiplied by the percentage of body surface actually burned, up to the Maximum Allowable Percentage for Area Surface Burned for each Area Classification Factor as shown on the Cosmetic Burns Schedule, and as determined by the attending Physician; and
3. steps 1 and 2 above determine a percentage, which is then multiplied by the Principal Sum as shown on the *Policy Schedule of Benefits.*

This benefit will be paid in addition to any other benefit payable under this Policy with the exception of a benefit paid under the Dismemberment, Loss of Speech or Hearing Benefit for the same area burned.

If an Insured Person suffers burns in more than one area as a result of any one Covered Activity, the calculation above shall be performed for each burned area. The maximum amount payable under this benefit shall not exceed 100% of the Principal Sum.

Cosmetic Burns Schedule

Body Part	Area Classification Factor	Maximum Allowable Percentage for Area Surface Burned	Percentage of Cosmetic Disfigurement From Burns Principal Sum *
Face, Neck, Head	11	9%	100%
Hand & Forearm (Right)	5	4.5%	22.5%
Hand & Forearm (Left)	5	4.5%	22.5%
Upper Arm (Right)	3	4.5%	13.5%
Upper Arm (Left)	3	4.5%	13.5%
Torso (Front)	2	18%	36%
Torso (Back)	2	18%	36%
Thigh (Right)	1	9%	9%
Thigh (Left)	1	9%	9%
Lower Leg (Right/below knee)	3	9%	27%
Lower Leg (Left/below knee)	3	9%	27%

*The percentage shown is based on 100% of the Body Part identified being burned.

II.D. PERMANENT PHYSICAL IMPAIRMENT BENEFIT
If a Covered Injury or a Covered Illness causes the Insured Person's Permanent Physical Impairment, We will pay up to the Principal Sum shown on the *Policy Schedule of Benefits*.

The benefit amount will be determined by the product of the impairment percentage assigned by a Physician multiplied by the Principal Sum. The impairment value is expressed as a percentage, taking into account the body part(s) permanently impaired as that part(s) related to the Insured Person's whole person. The Physician will determine the impairment value by use of the American Medical Association's "Guide to Evaluation of Permanent Impairment" most current at the time of claim.

If the Insured Person had a pre-existing physical impairment prior to the Covered Injury or Covered Illness, the impairment value of the pre-existing condition will be deducted from the impairment value calculated after the Covered Injury or Covered Illness.

Payment of the Principal Sum for Permanent Physical Impairment reduces the Principal Sum payable under this policy.

This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.

II.E. CRIMINAL ASSAULT BENEFIT
If an Insured Person suffers Loss due to a Covered Injury or Covered Illness resulting from a Criminal Assault that is directed at the Insured Person while performing his or her regular duties on behalf of the Participating Organizations during a Covered Activity, the Company will pay an additional benefit as shown on the *Policy Schedule of Benefits*.

Limitation on Criminal Assault - The Benefit Amount is not payable for Criminal Assault by the Insured Person or Insured Person's Immediate Family Member.

II.F. HOME ALTERATION OR VEHICLE MODIFICATION BENEFIT
If, due to Total Disability or Partial Total Disability, an Insured Person sustains a permanent physical limitation or impairment that poses a safety risk or inhibits an Insured Person's ability to maintain independence in his or her current transportation or living situation, the Company will pay the reasonable cost of the following Impairment Modifications:
1. alterations to an Insured Person's residence to make it wheelchair accessible and/or habitable; and
2. modifications necessary to a motor vehicle, owned by an Insured Person, to make the vehicle accessible or operable for an Insured Person.

The Impairment Modifications:
1. must be subject to a written agreement between the Insured Person and the Company which includes the costs and reasons for the modifications;
2. do not include charges that would not have been absent insurance; and
3. only include amounts incurred by the Insured Person for which he or she is not reimbursed by another source.

II.G. PARALYSIS BENEFIT
If an Insured Person suffers Paralysis resulting from a Covered Injury or Covered Illness, the Company will pay a Paralysis Benefit, provided that the Paralysis occurs within the time period from the Covered Injury or Covered Illness shown on the *Policy Schedule of Benefits*. The Benefit Amount is based on the type of Paralysis and shall be equal to the benefit percentage for that type of Paralysis shown below multiplied by the Principal Sum shown on the *Policy Schedule of Benefits.*

Paralysis	Benefit Amount
Quadriplegia	200% of the Principal Sum
Paraplegia	200% of the Principal Sum
Hemiplegia	200% of the Principal Sum

This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.

Definitions For the purposes of this Benefit:

Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than 365 days as determined by a Physician approved by Us.

Paralysis/Paralyzed means Quadriplegia, Paraplegia, Hemiplegia or Uniplegia that is expected to last for a continuous period of 12 months or more from the earlier of the date of the covered Accident causing paralysis or the date of the diagnosis.

Paraplegia means complete and irreversible loss of all motion and all practical use of both legs or both arms that lasts longer than 365 days, as determined by a Physician approved by Us.

Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs that lasts longer than 365 days, as determined by a Physician approved by Us.

II.H. BRAIN DAMAGE BENEFIT
If the Insured Person suffers a covered Loss that results in Brain Damage, the Company will pay the Benefit Amount shown on the *Policy Schedule of Benefits,* subject to all applicable conditions and exclusions. The benefit will be payable if all of the following conditions are met:

1. Brain Damage begins within 30 days from the date of the covered Loss;
2. the Insured Person is hospitalized for treatment of Brain Damage within the first 30 days following the covered Loss;
3. Brain Damage continues for 12 consecutive months;
4. a Physician determines that the Brain Damage is permanent, complete, and irreversible at the end of the 12 consecutive month period.

The benefit will be paid in one lump sum at the beginning of the 13th month following the date of the covered Loss if Brain Damage continues longer than 12 consecutive months. The amount payable will not exceed the Principal Sum for the Insured Person whose covered Loss is the basis of the claim.

Definitions For purposes of this benefit:

Brain Damage means physical damage to the brain that results directly and independently of all other causes from a Covered Injury or Covered Illness and causes the Insured Person to be unable to perform, without assistance, three (3) or more Activities of Daily Living (ADL).

Activities of Daily Living (ADL) means the following activities:

Bathing - the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment;

Dressing - the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;

Toileting - the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;

Transferring - the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment;

Eating - the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment; and

Continence - the ability to voluntarily maintain control of bowel and/or bladder function or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.

II.I. COMA BENEFIT
The Company will pay the Benefit Amount shown on the *Policy Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person suffers a Covered Injury or a Covered Illness that results in a Coma, within the applicable time period specified in the *Policy Schedule of Benefits*.

If an Insured Person dies within 365 days after the Accident, then We will pay a lump sum equal to the Insured Person's Principal Sum, less any Benefit Amount for Coma already paid.

Definitions For purposes of this Benefit:

Coma means a profound state of unconsciousness from which the Insured Person is not likely to be aroused through powerful stimulation. The Coma must begin within 30 days of the covered Accident, continue for 30 consecutive days and must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury or a Covered Illness unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of a Covered Injury or Covered Illness sustained in a covered Accident.

This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.

II.J. CANCER BENEFIT

We will pay the Benefit Amount shown on the *Policy Schedule of Benefits* to an Insured Person who is first diagnosed with "Life Threatening Cancer" within the term of coverage and requires medical treatment in the form of radiation or chemotherapy, if such treatment is received within one year from the onset of diagnosis and the Insured Person survives at least 30 days after such diagnosis. The Insured Person must be eligible and approved for Provincial Workers Compensation benefits.

"Life Threatening Cancer" - means a disease of the Insured Person which first manifested while the Insured Person's insurance under this contract is in effect and is a result of occupational hazards of the firefighter. "Life Threatening Cancer" must be characterized by the presence of a malignant tumor and by the uncontrolled growth and spread of malignant cells and the invasion of tissue. "Life Threatening Cancer" pertaining to this benefit includes; Leukemia, Non-Hodgkin's Lymphoma, Kidney Cancer, Brain Cancer and Bladder Cancer for which chemotherapy or radiation treatments have been recommended.

Diagnostic Requirements - "Life Threatening Cancer" must be positively diagnosed by a Physician and supported with a pathological report. Clinical diagnosis alone does not meet this standard.

Section III: INCOME PROTECTION BENEFITS

III.A. WEEKLY TOTAL DISABILITY BENEFITS

III.A.i. COVERED INJURY MINIMUM WEEKLY TOTAL DISABILITY BENEFIT
If an Insured Person is Totally Disabled as the result of a Covered Injury, the Company will pay the Minimum Weekly Benefit Amount shown on the *Policy Schedule of Benefits.* The Weekly Total Disability Benefit shall be payable for a period up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Injury.

III.A.ii. COVERED ILLNESS MINIMUM WEEKLY TOTAL DISABILITY BENEFIT
If an Insured Person is Totally Disabled as the result of a Covered Illness, the Company will pay the Minimum Weekly Benefit Amount shown on the *Policy Schedule of Benefits*. The Weekly Total Disability Benefit shall be payable for a period up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Illness.

III.A.iii. COVERED INJURY WEEKLY EARNED INCOME REPLACEMENT BENEFIT
If an Insured Person is Totally Disabled as a result of a Covered Injury and the Minimum Weekly Total Disability Benefit Amount is being paid, the Company will pay a Covered Injury Weekly Earned Income Replacement Benefit.

The amount of the Covered Injury Weekly Earned Income Replacement Benefit shall be computed as follows:
a. the Insured Person's Prior Weekly Earned Income less the combined total of:
b. the Covered Injury Minimum Weekly Total Disability Benefit Amount; and
c. the Loss of Earnings Coverage.

In no event will the Covered Injury Weekly Earned Income Replacement Benefit exceed the Maximum Weekly Benefit Amount shown on the *Policy Schedule of Benefits*.

The Covered Injury Weekly Earned Income Replacement Benefit will be paid for the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Injury.

III.A.iv. COVERED ILLNESS WEEKLY EARNED INCOME REPLACEMENT BENEFIT
If an Insured Person is Totally Disabled and the Covered Illness Minimum Weekly Total Disability Benefit is being paid, the Company will pay a Covered Illness Weekly Earned Income Replacement Benefit.

The amount of the Covered Illness Weekly Earned Income Replacement Benefit shall be computed as follows:
a. the Insured Person's Prior Weekly Earned Income less the combined total of:
b. the Covered Illness Minimum Weekly Total Disability Benefit Amount; and
c. the Loss of Earnings Coverage.

In no event will the Covered Illness Weekly Earned Income Replacement Benefit exceed the Maximum Weekly Benefit Amount shown on the *Policy Schedule of Benefits.*

The Covered Illness Weekly Earned Income Replacement Benefit will be paid for the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Illness.

III.B. PARTIAL DISABILITY BENEFIT
If an Insured Person suffers a Covered Injury or Covered Illness that results in a Partial Disability, the Company will pay a Partial Disability Benefit, as provided on the *Policy Schedule of Benefits*, if an Insured Person returns to any Reasonable Occupation at lower rate of Weekly Earned Income than he or she was earning prior to becoming Totally Disabled or Partially Disabled.

The Weekly Benefit Amount shall be computed as follows:
a. the Insured Person's Prior Weekly Earned Income less the combined total of:
b. earnings from any Reasonable Occupation; and
c. the Loss of Earnings Coverage.

In no event will the Partial Disability Benefit exceed the Maximum Weekly Benefit Amount shown on the *Policy Schedule of Benefits.*

The Partial Disability Benefit will be paid for the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Partially Disabled as a result of the Covered Injury or Covered Illness.

III.C. COST OF LIVING ADJUSTMENTS
After each Review Date, the Company will make Cost of Living Adjustments as set forth below:

If only the Covered Injury or Covered Illness Minimum Weekly Total Disability Benefit is payable, the Company will increase the benefit then payable by the greater of (a) 5% or (b) the CPI at the time. In no event will the increase exceed 8%.

If the Covered Injury or Covered Illness Minimum Weekly Total Disability Benefit and the Covered Injury or Covered Illness Weekly Earned Income Replacement Benefits are payable, the Company will increase the combined benefit then payable by the greater of (a) 5% or (b) the CPI at the time, of the Weekly Earned Income at the time the Insured Person's Disability began. In no event will the increase exceed 8%.

If, for 52 consecutive weeks, disability benefits are payable through a combination of the Covered Injury or Covered Illness Minimum Weekly Total Disability Benefit, Covered Injury or Covered Illness Weekly Earned Income Replacement Benefit, Partial Disability Benefits, or only Partial Disability Benefits, the company will increase the average weekly benefit paid during the prior 52 weeks by the greater of (a) 5% or (b) the CPI at the time. In no event will the increase exceed 8%.

These adjustments will be made after each Review Date and will be compounded. Any increased benefits apply to the 52 weeks of continuous disability immediately following the date of adjustment. In no event will any computed benefit exceed the Maximum Benefit Amount shown on the *Policy Schedule of Benefits.*

III.D. FIRST WEEK TOTAL DISABILITY BENEFIT
For the first week that an Insured Person is Totally Disabled due to a Covered Injury or Covered Illness, the Company will pay a benefit that shall be computed as follows:

a. the Insured Person's Prior Weekly Earned Income less the combined total of:
b. the Covered Injury or Covered Illness Minimum Weekly Total Disability Benefit;
c. the Covered Injury or Covered Illness Weekly Earned Income Replacement Benefit; and
d. Loss of Earnings Coverage.

In no event will the benefit exceed the Maximum Benefit Amount shown on the *Policy Schedule of Benefits.*

To the extent that the calculation above results in no loss of Weekly Earned Income, no benefit will be payable. This benefit shall be payable based on actual loss of Weekly Earned Income per day not to exceed the Maximum Benefit Amount shown on the *Policy Schedule of Benefits*.

III.E. TRANSITION BENEFIT
If an Insured Person is given a release to return to his or her primary employer after having received Minimum Weekly Total Disability payments, Weekly Earned Income Replacement payments, or Partial Disability payments under this Policy for a Covered Injury or Covered Illness, but his or her primary employer has terminated his or her employment due to the Covered Injury or Covered Illness that led to the Total Disability or Partial Disability, the Company will continue to pay disability benefits previously payable under this Policy for a period of up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits* while an Insured Person actively seeks employment.

III.F. RETRAINING BENEFIT
If the Insured Person and the Company agree upon a program of retraining in an Institution of Higher Learning, we will pay the tuition and books as charged by the institution as set forth in a written agreement between the Insured Person and us, up to the amount shown on the *Policy Schedule of Benefits*. The Company shall not pay for expenses incurred by the Insured Person for which he or she is reimbursed by another source.

The goal of the program of retraining must be to return the Insured Person to work in a Reasonable Occupation. We will review the program and the progress of the Insured Person in the program at the end of each of the institution's terms. We will continue to pay for the program as long as We determine that it is helping return the Insured Person to work.

Participation in the program by an Insured Person will not, in and of itself, be considered a recovery from a Total Disability or Partial Disability. Benefits for disability will continue as provided by the Policy while an Insured Person is actively participating in the program.

III.G. WEEKLY PERMANENT PHYSICAL IMPAIRMENT BENEFIT
If, due to a Covered Injury or Covered Illness for which the Insured Person is receiving Weekly Total Disability Benefits or Partial Disability Benefits, the Insured Person has a Permanent Physical Impairment percentage of 50% or greater (as described in the paragraph below), the Company will pay a benefit, up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits*.

The amount of the benefit will be determined by multiplying the Weekly Total Disability Benefit or Partial Disability Benefit payable during the last week of eligibility by the impairment percentage assigned by an examining Physician of Our choice. The impairment value shall be expressed as a percentage, taking into account the body part(s) permanently impaired as that part(s) relates to an Insured Person's whole person. The examining Physician will determine the impairment percentage by using the American Medical Association's *"Guide to Evaluation of Permanent Impairment"* most current at the time of the claim.

This benefit will begin during the first week after Weekly Total Disability Benefits or Partial Disability Benefits are no longer payable, and will continue to be paid for the remainder of the Insured Person's lifetime. This benefit will be paid in addition to any benefits paid or payable under the Policy.

If an Insured Person had a pre-existing physical impairment prior to the Covered Injury or Covered Illness, the impairment value of the pre-existing physical impairment will be deducted from the impairment value calculated after the Covered Injury or Covered Illness in order to determine the amount of the Weekly Permanent Physical Impairment Benefit.

EXCLUSIONS THAT APPLY TO THE INCOME PROTECTION BENEFITS
In addition to the Exclusions provided under the Policy, no Income Protection Benefits shall be payable in the following instances, unless coverage is specifically provided:
1. during the Insured Person's incarceration in a penal or corrections institution. Payments may resume after incarceration as long as the Insured Person remains Totally Disabled and remains covered under the Policy; or
2. the Insured Person is not receiving Appropriate Care.

LIMITATIONS AND CONDITIONS THAT APPLY TO THE WEEKLY TOTAL DISABILITY BENEFITS
The Weekly Benefit Amount for Total Disability shall be subject to the following limitations and conditions:

1) The Weekly Benefit Amount for Total Disability shall be excess of any other valid and collectible benefits under any Other Plan.
2) The total payments to the Insured Person for Total Disability from all sources, including the Weekly Benefit Amount for Total Disability and any other benefits, as stated in 1) above, shall not exceed the Insured Person's Prior Weekly Earned Income. If the total payments to the Insured Person from any other valid and collectible benefits under any Other Plan meet or exceed the Insured Person's Prior Weekly Earned Income, then the minimum Weekly Benefit Amount for Total Disability will be payable to the Insured Person by Us.
3) In no event will benefits be payable to an Insured Person for more than one disability at the same time.
4) An Insured Person may reopen his or her claim at any time up to 5 years following a period of Total Disability or Partial Disability for either Covered Injuries or Covered Illnesses for which payments were made under this Policy.
5) If an Insured Person is covered by multiple Accident Policies issued by the Company, the total amount of Income Protection Benefits payable under all policies will be a weekly benefit amount up to a maximum of $1,000.
6) If a Career Personnel Insured Person is approved for disability retirement or otherwise retires, all eligibility for Total Disability or Partial Disability terminates on the effective date of such retirement.
7) Total Disability or Partial Disability claims resulting from athletic events that are not Organized League Athletic Events will be limited to a maximum period of up to 156 weeks

Periods of Total Disability separated by less than fourteen (14) consecutive days of return to work will be considered one period of Total Disability, unless due to separate and unrelated causes. However, the Maximum Benefit Period shown on the *Policy Schedule of Benefits* will be reduced by the number of weeks for which benefits have already been paid, including but not limited to the Weekly Benefit Amount for Total Disability.

Section IV: MEDICAL EXPENSE BENEFITS

IV.A. EXCESS MEDICAL EXPENSE BENEFIT

The Company will pay 100% of the Reasonable and Customary Charges for the Covered Medical Expenses incurred by an Insured Person as a result of a Covered Injury or Covered Illness. The amount payable will be subject to the following conditions and limitations:

- The Company shall not pay more than the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* for all Covered Medical Expenses resulting from the same Covered Injury or Covered Illness.
- The Company may have a different Maximum Benefit Amount depending on whether the Covered Medical Expenses result from a Covered Injury or Covered Illness. The different amounts, if any, are contained on the *Policy Schedule of Benefits.*

EXCESS MEDICAL EXPENSE PROVISION

The Benefit Amount for the Excess Medical Expense Benefit is payable on an excess basis. We will determine the Reasonable and Customary Charge for the covered Medical Expense. We will then reduce that amount by amounts already paid or payable by any Other Plan. We will pay the resulting amount but in no event will We pay more than the Maximum Benefit Amount as shown on the *Policy Schedule of Benefits*.

IV.B. PLASTIC SURGERY EXPENSE BENEFIT

If the Insured Person incurs expenses for plastic surgery that is Medically Necessary due to a Covered Injury or Covered Illness, the Company shall provide an additional benefit, as shown on the *Policy Schedule of Benefits*.

EXCLUSIONS FOR MEDICAL EXPENSE BENEFIT AND THE PLASTIC SURGERY EXPENSE BENEFIT

In addition to the Exclusions provided under the Policy, no Medical Expense Benefit or Plastic Surgery Expense Benefits shall be payable for the following treatments or services, unless coverage is specifically provided:

1. for which an Insured Person has no obligation to pay;
2. for any injury or illness where worker's compensation benefits or occupational injury benefits are payable;
3. for treatment by a person employed or retained by the Policyholder or Organization;
4. for any injury occurring while fighting, except in self-defence;
5. for treatment that is educational, experimental or investigational in nature or that does not constitute accepted medical practice; or
6. for treatment involving conditions caused by repetitive motion injuries, or cumulative trauma and not as the result of an Covered Injury.

This insurance applies only to Medically Necessary charges and services.

IV.C. HOME HEALTH CARE EXPENSE BENEFITS

We will reimburse charges up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits*, if a covered Loss due to a Covered Injury or Covered Illness causes an Insured Person's confinement to home after a Hospital stay of at least fifteen (15) days. The expenses must be incurred within eighteen (18) months after the Covered Injury or Covered Illness. The Benefit Amount is payable on an excess basis. We will determine the charges for Home Health Care. We will then reduce that amount by amounts already paid or payable by any Other Plan. We will pay the resulting Benefit Amount, but in no event will We pay more than the Benefit Amount for Home Health Care shown on the *Policy Schedule of Benefits*.

No Benefit Amount for Home Health Care shall be paid if:

1) treatment is educational, experimental or investigational or does not constitute accepted medical practice; or
2) services are provided by a person who is an Immediate Family Member.

The Benefit Amount for Home Health Care is payable in addition to any other applicable Benefit Amounts under this policy.

Section V: ADDITIONAL BENEFITS

V.A. DAILY HOSPITAL CONFINEMENT AND OUTPATIENT TREATMENT BENEFIT

We will pay an In-Hospital Benefit Amount for each day an Insured Person is In-Hospital, if a Covered Injury or Covered Illness causes such Insured Person to be In-Hospital for at least one full day. For outpatient care, We will pay the daily amount shown on the *Policy Schedule of Benefits* for each day of treatment.

This benefit is payable in addition to any other applicable Benefit Amounts under this policy.

This benefit will be paid until the earliest of the date:

1) the Insured Person dies;
2) the Insured Person is no longer In-Hospital and/or no longer requires outpatient care; or
3) the Maximum Number of Days shown on the *Policy Schedule of Benefits* has elapsed.

In no event will total payment of the Daily Hospital Confinement and Outpatient Treatment Benefit Amount exceed the Maximum Number of Days shown on the *Policy Schedule of Benefits*.

Definitions For purposes of this Benefit:

In-Hospital means registered as an inpatient and confined to a Hospital while being treated by a Physician. In-Hospital does not include confinement solely for convalescent or nursing care. In-Hospital also means that the Insured Person is an outpatient requiring physical therapy, rehabilitation and/or follow-up physician visits.

V.B. DAILY CRITICAL CARE BENEFIT

If, due to a Covered Injury or Covered Illness, an Insured Person is Hospital confined to an intensive care, trauma, critical care, burn or similar specialty unit, the Company will pay the Daily Benefit Amount shown on the *Policy Schedule of Benefits* for each full day of such confinement. The number of days payable under this benefit will not exceed the Maximum Benefit Period shown on the *Policy Schedule of Benefits*. This payment is in lieu of the Daily Hospital Confinement Benefit.

V.C. FAMILY EXPENSE BENEFIT

If, as a result of a Covered Injury or Covered Illness, an Insured Person requires medical treatment that causes an Immediate Family Member or a significant other to accompany an Insured Person for treatment or to help treat an Insured Person, the Company will pay the following reasonable expenses actually incurred by the Immediate Family Member or significant other and not reimbursed by another source: loss of wages, out of pocket expenses, hotel accommodations, parking, childcare or other expenses reasonably related to treatment or care of the Insured Person. The most the Company will pay under this benefit is the Maximum Benefit Amount shown on the *Policy Schedule of Benefits*.

V.D. OCCUPATIONAL REHABILITATION BENEFIT

If an Insured Person is receiving Weekly Total Disability Benefits or Partial Disability Benefits, he or she may be eligible for a rehabilitation program. The Company will pay up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* for the program as set forth in a written agreement. The goal of the rehabilitation program will be to return an Insured Person to the workforce in a Reasonable Occupation for which he or she is reasonably suited considering the Covered Injury or Covered Illness sustained.

The Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other services. The other services and expenses that might be provided may include:

- coordination of physical rehabilitation and medical services;
- financial and business planning;
- vocational evaluation and transferable skills analysis;
- career counseling and retraining;
- labor market surveys and job placement services; and
- evaluation of necessary worksite modifications and adaptive equipment and may include work on a part time basis.

The Company can periodically review the program and an Insured Person's progress. The Company will continue to pay for the program as long as the Company determines that the program is helping an Insured Person return to the workforce.

An Insured Person's participation in a rehabilitation program will not, in and of itself, be considered a recovery from Total Disability or Partial Disability. Benefits for Weekly Total Disability or Partial Disability will continue as provided by the Policy while an Insured Person is actively participating in the program.

V.E. MENTAL STRESS MANAGEMENT BENEFIT

If an Insured Person suffers psychiatric or mental stress illness as a direct result of either being actively engaged in a single emergency incident or repeated active engagement in emergency incidents as a member of the Participating Organizations, the Company will pay a Mental Stress Management Benefit, in accordance with Sections III, IV and V of this Policy, subject to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits.* The Insured Person must be receiving care by a Physician properly licensed to provide such care and the care must be appropriate for the condition causing the psychiatric or mental stress.

V.F. TRAUMATIC INCIDENT BENEFIT

The Company will pay the reasonable expenses for the services provided by a Traumatic Incident Stress Management Team if such services are requested and authorized by the Participating Organizations as a result of a Traumatic Incident. Expenses must be incurred within the time specified on the *Policy Schedule of Benefits* and are subject to the Aggregate Maximum Benefit Amount shown on the *Policy Schedule of Benefits*. The Aggregate Maximum Benefit Amount is the maximum that will be paid per Traumatic Incident, regardless of the number of Insured Persons treated.

CLAIMS PROVISIONS

CLAIM FORMS
Our administrator will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the Company received notice of claim, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made. The notice should include the Insured Person's name, the Participating Organizations' names and the Policy number. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

NOTICE OF CLAIM
A written incident report must be made to the Participating Organizations or Our administrator within 30 days, or as soon as reasonably possible, after the Covered Activity that may give rise to a loss under this Policy. Written notice of claim must be given to Our administrator within 30 days after the occurrence or commencement of the Insured Person's Covered Injury or Covered Illness or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company or to its designated authorized agent, with information sufficient to identify the Insured Person, is deemed notice to the Company. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form.

PROOF OF LOSS
In case of a claim for loss of time from disability, written proof of loss must be furnished within ninety (90) days of the date of such loss, or as soon as reasonably possible. Subsequent written proof of the continuance of such disability must be furnished at such time, in such manner and at such place as We may reasonably require.

For any loss other than a disability loss, written proof of loss must be furnished within ninety (90) days after such loss, or as soon as reasonably possible.

Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to furnish proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

PAYMENT OF CLAIMS
All benefits will be paid in Canadian currency. After We received written proof of loss of time due to disability, disability benefits payable under the Policy for loss of time will be paid monthly during the continuance of the period for which the Company is liable. Benefits for any other loss covered by this Policy will be paid immediately after proof of loss is received but not more than 30 (thirty) days after proof of loss is received. The balance of any unpaid benefits at the termination of the period for which the Company is liable will be paid as soon as possible after receipt of proof. Any payment We make in good faith will end Our liability to the extent of the payment of Loss of Life claims.

PAYMENT OF LOSS OF LIFE CLAIMS
Upon receipt of due written proof of death, unless otherwise indicated in a specific benefit, benefits for a Loss of Life claim will be paid to the beneficiary named by an Insured Person when he or she became covered under this Policy. An Insured Person has the right to change his or her beneficiary at any time by completing a form, approved by Us, and submitting it to the Participating Organizations. The new beneficiary designation will be effective as of the date an Insured Person signed the required form. However, if We have taken any action or made any claim payment before the Participating Organizations receives an Insured Person's request to change his or her beneficiary, that change will not go into effect.

If an Insured Person does not name a beneficiary or names more than one beneficiary but does not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before an Insured Person, or the share of a beneficiary who is disqualified will pass to any surviving beneficiaries in the order designated by an Insured Person.

If an Insured Person does not name a beneficiary, or if a named beneficiary is disqualified, or if all named beneficiaries die before an Insured Person, We have the option of paying death benefits to an Insured Person's estate or surviving family members in the order listed below:

1. Spouse;
2. child or children, equally if living;
3. mother or father, equally or to the survivor; or
4. sisters or brothers, equally or to the survivor or survivors.

With respect to Insured Persons living in Quebec, the beneficiary designation of a Spouse is irrevocable, unless otherwise stipulated. Any other beneficiary is revocable.

COOPERATION OF THE INSURED PERSON

Coverage under this Policy may terminate for any Insured Person who fails to cooperate with the Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

RIGHT TO OFFSET

If We determine that an overpayment of any benefit payable under this Policy has been made to an Insured Person due to fraud or any error We make in processing a claim, We reserve the right to:

1. offset said overpayment against any amounts otherwise payable to an Insured Person;
2. request reimbursement from an Insured Person for any overpayment made; or
3. bring legal action against an Insured Person to recover any overpayment.

RIGHT OF RECOVERY

If an Insured Person incurs expenses due to a Covered Injury or Covered Illness and the loss is caused by the act or omission of another person, an Insured Person may have a claim against the other person. If recovery is made, an Insured Person must repay us the recovery made from: (1) the other person; or (2) the other person's insurer. We will only have such right against excess funds and only if an Insured Person is made whole.

This right of recovery provision also applies when an Insured Person receives payment under an uninsured or underinsured motorist insurance policy or plan.

PHYSICAL EXAMINATION AND AUTOPSY

We, at Our expense, have the right to have an Insured Person examined as often as is reasonable while a claim is pending. We may also request to have an Insured Person examined, at Our expense, as proof of continued loss. We reserve the right to select the examiner. In the case of death, We may request to have an autopsy performed where it is not forbidden by law.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after the required proof of loss is furnished in accordance with the terms of this Policy. No action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Policy.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Ontario *Limitations Act, 2002*.

To the extent that the Policy is subject to the Insurance Act of British Columbia, Alberta, or Manitoba, the following provision applies:

> Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act*.

LEGAL EXPENSE

If, while receiving benefits under this Policy, an Insured Person incurs legal expenses for the denial or appeal of a Workers' Compensation claim related to Covered Injury or Covered Illness with the in-force Workers' Compensation carrier, We will reimburse an Insured Person for such expenses up to a maximum of $1,000. In no event will benefits be payable for liability, negligence or any other related lawsuit or action other than those specifically stated in this Policy. This benefit is payable for up to one (1) year following the date of the Covered Activity.

CHANGE OF BENEFICIARY

The right to change of beneficiary is reserved to the Insured Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy, to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

SUBROGATION FOR INCOME PROTECTION BENEFITS

After the Insured Person has been fully compensated for his or her Covered Loss, the Company has the right to recover all Income Protection Benefit payments including future payments, which the Company has made, or will be obligated to pay in the future, to the Insured Person from anyone liable for the covered loss. If the Insured Person recovers from anyone liable for the covered loss, the Company will be reimbursed first from such recovery to the extent of the Company's payments to the Insured Person. The Insured Person agrees to assist the Company in preserving its rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by the Company.

To the extent that the Policy is subject to the laws of Quebec, if the Insured Person has only received partial indemnification of his or her total loss by the coverage afforded under this Policy, the Insured Person will have priority over the Company to be reimbursed by amounts recovered from anyone found liable for the Covered Loss up to an amount corresponding to the uninsured and outstanding balance of the Insured Person's total loss.

PREMIUMS AND RENEWALS PROVISIONS

POLICY TERM AND RENEWAL

The first term of this Policy starts on the Effective Date shown on the *Policy Schedule of Benefits* and ends on the Expiration Date, also shown on the *Policy Schedule of Benefits*. The Policy will remain in effect for the duration of the Policy Term if the premium is paid according to the agreed upon terms. Later terms will be the periods for which the Policyholder pays renewal premiums agreed upon when due. All terms will begin and end at 12:01 A.M., Standard Time, at the location of the Policyholder.

The Company or the Policyholder may terminate this Policy on any anniversary of the first Renewal Date by giving the other party written notice at least thirty (30) days prior to that date. In that event, this Policy will terminate on the specified anniversary date at 12:01 A.M., Standard Time. Any premium rate guarantee will not affect the Company's or the Policyholder's right to terminate this Policy. Termination or nonrenewal will be without prejudice to the rights of any Insured Person with respect to any benefits payable under this Policy that began while this Policy was in force.

PREMIUMS

Premiums are paid at the Company's home office or to the Company's authorized agent. Any premium remitted by the Policyholder to its agent or broker will not be considered paid until it is received by us at Our office. If any premium is not paid when due, this Policy will be cancelled at the end of the last period for which premium was paid, except as provided in the Grace Period provision.

The first premium is due on the Effective Date shown on the *Policy Schedule of Benefits*. The renewal premium for each term will be due on the day the preceding term ends, subject to the Grace Period**,** unless the Policyholder and the Company agree to another mode of premium payment.

We may change the premium rate on any Renewal Date of this Policy or whenever the terms or conditions of the Policy are changed.

PREMIUM RATE CHANGES

The Company may change premium rates at the end of any Policy Term or any Premium Rate Guarantee Period with at least 31 days advance notice mailed to the last known address of the Policyholder. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

The Company may change the premium rate during a Policy Term or during any applicable Premium Rate Guarantee Period if any one of the following occurs:

1. the terms of this Policy change;
2. the number of Insured Persons or Eligible Persons for coverage increases or decreases by more than 25% since the later of the Policy Effective Date and the date of the last renewal of this Policy;
3. coverage is reinstated following failure to pay premium during the Grace Period;
4. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 25% or more the number of Insured Persons;
5. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this Policy.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

GRACE PERIOD

A grace period of thirty-one (31) days will be provided for the payment of any premium due after the first. During the grace period, the Policy shall continue in force, unless the Policyholder has given written notice of discontinuance in advance of the premium due date and in accordance with the Policy Term and Renewal provision.

Any renewal premium due must be paid, to Us, within the grace period following the renewal premium due date. If renewal premium is not paid within the thirty-one (31) day grace period, this Policy will automatically terminate at the end of the grace period. The Policyholder will be liable for the payment of a pro rata premium for the time the Policy was in force during the grace period.

PREMIUM AUDIT
The Company will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

REINSTATEMENT
This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are a written application of the Policyholder satisfactory to the Company and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid but not to any period more than sixty days prior to the date of reinstatement.

GENERAL PROVISIONS

ENTIRE CONTRACT
This Policy, including the application (if any) and any attached amendments, endorsements, riders and/or attached papers represents the entire contract between the Policyholder and the Company. All statements made by the officers or trustees of the Policyholder shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Person will be used in any contest under this Policy unless a copy of the statement is furnished to the Insured Person, or in the event of death or incapacity of the Insured Person, to the Insured Person's beneficiary or personal representative. No change in this Policy will be effective until approved by one of Our officers. This approval must be in writing and endorsed on or attached to this Policy. No agent can change this Policy or waive any of its provisions.

CONFORMITY WITH STATUTES
This policy is governed by the laws of the province in which it is delivered to the Policyholder and the laws of Canada applicable therein. Any terms of this policy which are in conflict with the applicable statutes, laws, or regulations of the jurisdiction in which this policy is delivered are amended to conform to such statutes, laws, or regulations.

WORKERS' COMPENSATION
This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law. This Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

ADDITION OF NEW INSURED PERSONS
All Insured Persons added to the Classes of Eligible Persons in the *Policy Schedule* are eligible for insurance under this Policy.

ASSIGNMENT
The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if the Company receives it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Injury or Covered Illness. Any other attempt to assign will be void.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

REPLACEMENT OF A CONTRACT OF GROUP INSURANCE
Where this Policy replaces another contract of group insurance on some or all of the Insured Persons, the designation of an Insured Person, the Insured Person's representative, and the Insured's Person's beneficiaries to whom money is payable under the replaced contract will not apply to the Policy.

REPLACEMENT OF A PREVIOUS GROUP ACCIDENT INSURANCE CONTRACT IN QUEBEC
To the extent that the Policy is subject to the laws of Quebec:

If the Policy replaces another group accident insurance contract, that had provided comparable coverage for all or part of the group of Insured Persons, the following provisions will apply:

a) a person insured under the former contract may not be excluded from the Policy or be denied benefits solely because of a pre-existing condition limitation that did not apply or exist under the former contract, or because the person is not at work when the Policy came into force; and

b) every person insured under the former contract is an Insured Person under the Policy on the termination of the former contract if the cessation of insurance was only due to such termination and if the person belongs to a class of Eligible Persons under the Policy.

CLERICAL ERROR
An Insured Person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, the Company will adjust the premium fairly.

EXAMINATION OF THE POLICY
This Policy will be available for inspection at the Policyholder office during regular business hours.

INCONTESTABILITY
The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, misrepresentation or fraud.

Absent a showing of intentional fraud, no statement made by any Insured Person relating to insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime nor unless the statement is contained in a written instrument signed by the person making the statement.

However, the Company may contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Policy.

MISSTATEMENT OF FACT
If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

NONCOMPLIANCE WITH POLICY REQUIREMENTS
Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.

RECORDS
The Policyholder or its authorized Administrator will maintain the records of the Insured Person’s insurance under this Policy. The Company will be permitted to examine the Policyholder’s records relating to the insurance under this Policy at any reasonable time. The Policyholder is acting as an agent of the Insured Person for transactions relating to this insurance. The actions of the Policyholder will not be considered the actions of the Company.

CONDITIONS ON EXPIRY OR CANCELLATION IN QUEBEC
To the extent that the Policy is subject to the laws of Quebec:

The expiry or cancellation of this Policy may not be set up against a Covered Loss based on death, mutilation arising from an accident, disability, or sickness that occurred while the Policy is in force.

The Company will continue to compensate an Insured Person for any salary loss qualifying for coverage under the Policy if the Insured Person is still disabled after the Policy expires. The Company is not bound to compensate the Insured Person if the disability recurs after the expiry of the Policy and the Insured Person has not been disabled for more than 180 days.

TERRITORY
This insurance applies worldwide.

BLANKET ACCIDENT INSURANCE POLICY

Underwritten by:
AXIS REINSURANCE COMPANY (CANADIAN BRANCH)

Underwriting Office:
70 York Street
Suite 1010
Toronto, Ontario M5J1S9

The Company will pay the benefits of this Policy subject to its provisions. This page and the pages that follow are part of this Policy.

AXIS Reinsurance Company (Canadian Branch) insures the members of:

POLICYHOLDER: **Anytown, Canada Emergency Services Organization**

POLICY EFFECTIVE DATE: December 1, 2022 POLICY NUMBER: EXAD-XXXXX-XXXXXXX

POLICY TERM: 12/01/2022 through 11/30/2023 POLICY ANNIVERSARY DATE: December 1

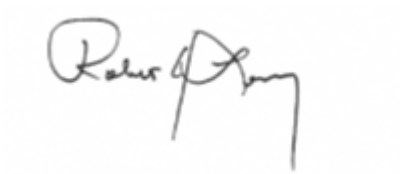
AXIS Reinsurance Company (Canadian Branch) (referred to as the Company, We, Our, or Us) will pay the benefits provided by this Policy in return for the payment of premium. AXIS Reinsurance Company makes this promise subject to all of this Policy's provisions.

The Policy is a legal contract between the Policyholder and the Company.

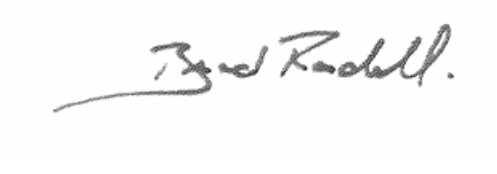
This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 A.M. on the Policy Effective Date at the Policyholder's address. It will remain in effect for the duration of the Policy Term if the premium is paid according to the agreed terms. This Policy terminates at 12:00 A.M., on the day following the last day of the Policy Term unless the Policyholder and the Company agree to continue coverage under this Policy for an additional Policy Term.

The Company and the Policyholder agree to all the terms of this Policy.

The President, Chief Agent, and Secretary of the Company witness this Policy.



Robert J. Looney, Jr.
President & CEO



Brad Randell
Chief Agent for Canada

Andrew M. Weissert
Secretary

THIS IS A LIMITED POLICY
IT PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS
PLEASE READ IT CAREFULLY
NON-PARTICIPATING

Table of Contents

SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, PLEASE READ ALL THE POLICY PROVISIONS CAREFULLY.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the Conditions of Coverage and Description of Benefits sections for full details.

Eligible Persons: An Eligible Person is an individual who meets all of the requirements of one of the covered classes shown below:

Class	**Principal Sum**
Class I Active Members of the Policyholder who have elected Member Only Coverage	$100,000
Class II Active Members of the Policyholder and their Spouse and eligible Dependent Children for whom the member has elected Family Coverage	Member: $100,000 The Spouse's Principal Sum is equal to 50% of the member's Benefit Amount. Each Dependent Child's Principal Sum is equal to 15% of the member's Principal Sum. If there is only a Spouse, the Spouse's Principal Sum is equal to 60% of the member's Benefit Amount. If there is only a Dependent Child, the Dependent Child's Principal Sum is equal to 20% of the member's Benefit Amount.

INCONTESTABILITY
The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, misrepresentation or fraud.

Absent a showing of intentional fraud, no statement made by any Insured Person relating to insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime nor unless the statement is contained in a written instrument signed by the person making the statement.

However, the Company may contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Policy.

MISSTATEMENT OF FACT
If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

NONCOMPLIANCE WITH POLICY REQUIREMENTS
Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.

RECORDS
The Policyholder or its authorized Administrator will maintain the records of the Insured Person’s insurance under this Policy. The Company will be permitted to examine the Policyholder’s records relating to the insurance under this Policy at any reasonable time. The Policyholder is acting as an agent of the Insured Person for transactions relating to this insurance. The actions of the Policyholder will not be considered the actions of the Company.

CONDITIONS ON EXPIRY OR CANCELLATION IN QUEBEC
To the extent that the Policy is subject to the laws of Quebec:

The expiry or cancellation of this Policy may not be set up against a Covered Loss based on death, mutilation arising from an accident, disability, or sickness that occurred while the Policy is in force.

The Company will continue to compensate an Insured Person for any salary loss qualifying for coverage under the Policy if the Insured Person is still disabled after the Policy expires. The Company is not bound to compensate the Insured Person if the disability recurs after the expiry of the Policy and the Insured Person has not been disabled for more than 180 days.

TERRITORY
This insurance applies worldwide.

SECTION II: IMPAIRMENT BENEFITS

	Class I	Class II
II.A. DISMEMBERMENT, LOSS OF SPEECH OR HEARING BENEFIT		
Principal Sum	$150,000	$150,000
II.B. VISION IMPAIRMENT BENEFIT		
Principal Sum	$150,000	$150,000
II.C. COSMETIC DISFIGUREMENT FROM BURNS BENEFIT		
Principal Sum	$150,000	$150,000
II.D. PERMANENT PHYSICAL IMPAIRMENT BENEFIT		
Principal Sum	$150,000	$150,000
II.E. CRIMINAL ASSAULT BENEFIT		
Benefit Amount	50% of the total amount payable under the following benefits: Covered Injury Death Benefit, Dismemberment, Loss of Speech or Hearing Benefit, Vision Impairment Benefit, Cosmetic Disfigurement from Burns Benefit, Permanent Physical Impairment Benefit, Paralysis Benefit, or Weekly Total or Partial Disability Benefits, subject to an overall maximum benefit of $75,000	50% of the total amount payable under the following benefits: Covered Injury Death Benefit, Dismemberment, Loss of Speech or Hearing Benefit, Vision Impairment Benefit, Cosmetic Disfigurement from Burns Benefit, Permanent Physical Impairment Benefit, Paralysis Benefit, or Weekly Total or Partial Disability Benefits, subject to an overall maximum benefit of $75,000
II.F. HOME ALTERATION OR VEHICLE MODIFICATION BENEFIT		
Maximum Benefit Amount	actual expenses up to $50,000	actual expenses up to $50,000
II.G. PARALYSIS BENEFIT		
Principal Sum	$300,000	$300,000
Paralysis must occur within	365 days of the Covered Injury or onset of Covered Illness	365 days of the Covered Injury or onset of Covered Illness
II.H. BRAIN DAMAGE BENEFIT		
Benefit Amount	$150,000	$150,000
II.I. COMA BENEFIT		
Benefit Amount	1% of the Principal Sum per month	1% of the Principal Sum per month
Maximum Benefit Amount	$150,000	$150,000
Coma must occur within	30 days of the Covered Injury or onset of Covered Illness	30 days of the Covered Injury or onset of Covered Illness
II.J. CANCER BENEFIT		
Benefit Amount	$7,500	$7,500
Diagnosis must occur within	Policy Term	Policy Term
Treatment must occur within	1 year of diagnosis	1 year of diagnosis
Survival Period	30 days after diagnosis	30 days after diagnosis

CONDITIONS OF COVERAGE

The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages:

Class I

MEMBERS COVERAGE

Covered Activities	24-Hour excluding Covered Activities

Class II

MEMBERS & FAMILY COVERAGE

Covered Activities	24-Hour excluding Covered Activiies

BENEFITS

Aggregate Limit of Indemnity:
Benefit Amount: $5,000,000

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses and Covered Injuries suffered by all Insured Persons as the result of any one (1) Covered Accident that occurs under one of the Conditions of Coverage, as specified above. This Aggregate Limit of Indemnity is payable only once, should more than one Condition of Coverage apply, We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

Maximum Payment for Multiple Losses and Multiple Benefits:
For any Benefit Amount identified as subject to this provision in the *Schedule of Benefits*, payment of such Benefit Amount will reduce the Principal Sum. If, subject to all the terms and conditions of this policy, an Insured Person is entitled to receive payment of multiple Benefit Amounts as the result of one (1) Accident, then the maximum We will pay for all benefits shall not exceed the Principal Sum, with the exception of Quadriplegia, Paraplegia and Hemiplegia.

For any Benefit Amount identified as not subject to this provision in the *Schedule of Benefits*, payment of such Benefit Amount will be in addition to any Principal Sum payable under this policy.

If an Insured Person has multiple Losses as the result of one (1) Accident, then the maximum Benefit Amount We will pay shall not exceed 100% of the Principal Sum with the exception of Quadriplegia, Paraplegia and Hemiplegia. In no event will the maximum Benefit Amount We will pay exceed 200% of the Principal Sum.

For the purposes of this provision the definition of Loss includes Brain Damage, Coma, Vision Impairment.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss must occur within	365 days of the Covered Accident
Covered Loss	**Benefit Amount**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Speech or Hearing in Both Ears	100% of the Principal Sum
Loss of One Hand or Foot	75% of the Principal Sum
Loss of One Arm or One Leg	80% of the Principal Sum
Loss of Hearing in One Ear	67% of the Principal Sum
Loss of Thumb or Index Finger of either Hand	25% of the Principal Sum
Loss of Second, Third, or Fourth Finger on either Hand	12.5% of the Principal Sum
Loss of Any Joint on either Hand	6.25% of the Principal Sum
Loss of a Joint of either hand or foot	6.25% of the Principal Sum
Exposure and Disappearance	Included

PARALYSIS BENEFIT

Covered Loss must occur within	365 days of the Covered Accident
Benefit Amount	
Quadriplegia	200% of the Principal Sum
Paraplegia	200% of the Principal Sum
Hemiplegia	200% of the Principal Sum

BRAIN DAMAGE BENEFIT

Loss must occur within	365 days of the Covered Accident
Benefit Amount	100% of the Principal Sum
Activities of Daily Living	3 of 6 Activities of Daily Living

This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.

COMA BENEFIT

Loss must occur within	30 days of the Covered Accident
Benefit Amount	1% of the Principal Sum per month, subject to a Maximum Benefit of 100% of the Principal Sum. *This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.*

VISION IMPAIRMENT BENEFIT

Loss must occur within	365 days of the Covered Accident

Vision Impairment Chart

Degree of Vision Impairment	Benefit Amount (as a percentage of Principal Sum payable for each eye)
20/20	0.00%
20/30	2.75%
20/40	5.50%
20/50	8.25%
20/60	11.00%
20/80	16.50%
20/100	22.00%
20/120	28.00%
20/150	36.00%
20/180	45.50%
20/200 or worse	50.00%

This Benefit Amount is subject to the Maximum Payment for Multiple Losses and Multiple Benefits.

TEMPORARY TOTAL DISABILITY WEEKLY INCOME BENEFIT

Description	Benefit Amount	Maximum Weeks	Elimination Period
Employed Members	100% of gross income maximum of $400 minimum of $100	104 weeks	7 days
Unemployed Members	$100	13 weeks	7 days
Spouses	$100	13 weeks	7 days

BEREAVEMENT EXPENSES BENEFIT

Benefit Amount	$5,000

CHILD CARE EXPENSE BENEFIT

Maximum Benefit Amount Per Child	$5,000 per year
Maximum Benefit Amount	$50,000

DEPENDENT CHILD EDUCATION EXPENSE BENEFIT

Maximum Benefit Amount	$5,000 per year per child
Maximum Benefit	$20,000 per child

FAMILY TRAVEL EXPENSE BENEFIT

Maximum Benefit Amount	$20,000

FUNERAL EXPENSE BENEFIT

Benefit Amount	$5,000

HOME ALTERATION OR VEHICLE MODIFICATION BENEFIT

Maximum Benefit Amount	$15,000

HOME HEALTH CARE EXPENSE BENEFITS

Maximum Benefit Amount	$20,000
Maximum Benefit Period	18 months
Minimum Preceding Hospital Stay	15 days

IDENTIFICATION EXPENSE BENEFIT

Maximum Benefit Amount	$15,000

PARENT CARE BENEFIT

Benefit Amount per Dependent Parent	$5,000 per year
Maximum Benefit Amount for all Dependent Parents	$40,000

PSYCHOLOGICAL THERAPY EXPENSE

Maximum Benefit Amount	$10,000

REHABILITATION EXPENSE BENEFIT

Maximum Benefit Amount	$20,000
Maximum Benefit Period	24 months

REPATRIATION EXPENSE BENEFIT

Maximum Benefit Amount	$20,000

SEATBELT AND OCCUPANT PROTECTION DEVICE BENEFIT

Benefit Amount for Seat Belt	20% of the Principal Sum
Benefit Amount for Occupant Protection Device	10% of the Principal Sum

SURVIVING SPOUSE EDUCATION BENEFIT

Maximum Benefit Amount	$20,000
Maximum Benefit Period	3 years

PREMIUM RATE TABLE

It is hereby agreed and understood that the premium amounts, and the manner in which premiums are due and payable, are as follows:

Class	Plan Option	Annual Rates Per Member	Number of Members	Class Premium
1	Member	$61	20	$1,220
2	Member & Family	$98	0	$0

TOTAL PREMIUM: $1,220

Premium Due Date: Policy Effective Date

The initial premium rate guarantee and any premium rate guarantee applicable to renewal are subject to the Cancellation and Premium Rate Change sections of the Administrative Provisions of this Policy.

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Accident or Accidental means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.

Aircraft means a vehicle which:
1. has a valid Airworthiness Certificate; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Bereavement Expenses means the Usual and Customary charges incurred by the Insured Person's Spouse and Dependent Children for grief counselling by a Professional Counsellor.

Calendar Year means January 1st through December 31st of any year.

Child Care Expense means the actual incurred costs for the care and supervision of an Insured Person's Dependent Child who is less than age 13.

Conveyance means a motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority.

Covered Accident means an Accident that results in a Covered Loss during the Policy Term.

Covered Activity or Covered Activities means any activity which is normal for an Insured Person while acting on behalf of the Policyholder and includes travel directly to and from such activity, as well as impromptu action (Good Samaritan) at the scene of an emergency regardless of the Policyholder's involvement. Covered Activity also means all Organized sponsored by the Policyholder**.**

Covered Expenses means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.

Covered Injury means Accidental bodily injury: (1) which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force; and (2) which results directly and independently from all other causes; and (3) which occurs while such person is **not** participating in a Covered Activity (Off Duty). The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Covered Loss means a loss which meets the requisites of one or more benefits, and results from a Covered Accident, Covered Injury or Covered Activity.

Dependent Child means an Insured Person's unmarried child from the moment of birth, including a natural child, grandchild, stepchild or adopted child from the date of placement with an Insured Person. The Dependent Child must be primarily dependent upon such Insured Person for maintenance and support, and must be:

1) under the age of twenty-three (23);
2) under the age of twenty-six (26) if enrolled as a full-time student at an Institution of Higher Learning; or
3) classified as an Incapacitated Dependent Child.

Dependent Parent means the parent(s) or grandparent(s) of an Insured Person or Spouse who, at the time of a Covered Injury is receiving support and care provided by the Insured Person or Spouse as evidenced by Canadian income tax returns showing the parent or grandparent as a dependent.

Eligible Person means an individual as defined in the *Schedule of Benefits*.

Gainful Occupation means an occupation, including self employment, that is or can be expected to provide an Insured Person with an income which is the lesser of $75,000 or 70% of the Insured Person's Prior Weekly Earned Income within twelve (12) months after the Insured Person's return to work.

He, His, Him refers to any individual, male or female.

Hospital means an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and
6. it charges for its services.

Hospital Confinement, Hospital Stay or Confined to a Hospital means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least 30 days.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, domestic partner; brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), grandparents; grandchildren, aunts, uncles, nieces, or nephews.

Incapacitated Dependent Child means a child who, as a result of being mentally or physically challenged, is permanently incapable of self-support and permanently dependent on an Insured Person for support and maintenance. The incapacity must have occurred while the child was:

1) under the age of twenty-three (23); or
2) under the age of twenty-six (26) if enrolled as a full-time student at an Institution of Higher Learning.

Institution of Higher Learning means any accredited public or private college, university, professional trade or vocational school beyond the twelfth (12th) grade.

Insured Person means an Eligible Person, as defined in the *Schedule of Benefits*, for whom required premium has been paid when due and for whom coverage under this Policy remains in force.

Medically Necessary means medical services that: (1) are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) are ordered by a Physician and performed under His care, supervision or order.

Nurse means a licensed graduate Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) who is not:

1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household; or
4. a person employed or retained by the Policyholder.

Other Plan means any other insurance or payment source for disability, including but not limited to health coverage, primary disability insurance, worker's compensation insurance; or coverage provided or required by any law or statute, including, automobile insurance "fault" or "no-fault", employer sick leave or salary continuation plan, or similar benefit provided or required by governmental plan or program.

Paralysis/Paralyzed means Quadriplegia, Paraplegia, or Hemiplegia that is expected to last for a continuous period of 12 months or more from the earlier of the date of the Covered Activity that caused the Paralysis or the date of the diagnosis. "Quadriplegia" means the complete and irreversible Paralysis of both upper and lower limbs. "Paraplegia" means the complete and irreversible Paralysis of both lower limbs or both upper limbs. "Hemiplegia" means the complete and irreversible Paralysis of the upper and lower limbs of the same side of the body. "Limb" means entire arm or entire leg.

Physician means a licensed health care provider practicing within the scope of his license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:

1 the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Policy Term means the time period defined for the Policyholder shown on this Policy's face page.

Policyholder means the entity, named on this Policy's face page, to which the Company issues this Policy.

Prior Weekly Earned Income

is the greater of the Insured Person's:

1) Weekly Earned Income at the time the disability starts; or
2) average Weekly Earned Income for the period of twelve (12) weeks prior to the start of disability for which a claim is made; or
3) average Weekly Earned Income for the period of one year prior to the start of disability for which a claim is made.

Private Passenger Automobile

means a validly registered, four wheel private passenger car, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxi cab, bus or other public Conveyance will not be considered a Private Passenger Automobile.

Professional Counsellor

means a therapist or counsellor who is licensed, registered or certified to provide such treatment

Psychological Therapy

means Medically Necessary counselling for a mental or nervous disorder by a Physician, whether on an out-patient basis, in a Hospital or any other medical facility licensed to provide such treatment.

Psychological Therapy Expense

means Usual and Customary Charges for Psychological Therapy

Rehabilitation

means treatment other than Psychological Therapy intended to prepare an Insured Person for work in any Gainful Occupation, including an Insured Person's regular occupation that is:

1) provided by a therapist licensed, registered, or certified to perform such treatment; or
2) provided in a Hospital or other facility, which is licensed to provide such treatment.

The Rehabilitation must take place under the direction of a Physician

Rehabilitation Expense

means Usual and Customary Charges for Rehabilitation.

Spouse

means a person of the same or opposite sex who:

1) is legally married to and cohabits with the Insured Person, or if there is no such person,
2) is a person who qualifies as a common law or domestic partner under the provisions of any applicable federal, provincial, territorial, or local law.

Terrorism means activities against persons, organizations or property of any nature:

1) that involve the following or preparation for the following:
   a) use or threat of force or violence; or
   b) commission or threat of a dangerous act; or
   c) commission or threat of an act that interferes with or disrupts an electronic, communication, information or mechanical system; and
2) when one or both of the following applies:
   a) the effect is to intimidate or coerce a government or the civilian population or any segment thereof, or to disrupt any segment of the economy; or
   b) it appears that the intent is to intimidate or coerce a government, or to further political, ideological, religious social, or economic objectives or to express (or express opposition to) a philosophy or ideology.

Usual and Customary Charge means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

We, Us, Our means AXIS Reinsurance Company (Canadian Branch).

Weekly Earned Income means the Insured Person's weekly earnings from all sources for regular, over-time and shift differential wages. Weekly Earned Income shall be substantiated by pay stubs, Canadian Individual Income Tax Return, other employment records, tax records and/or any other records which We may reasonably request. The Weekly Earned Income must be verified by the Insured Person's employer and/or tax records.

If the Insured Person is self-employed, We will compute Weekly Earned Income from the amount reported by the Insured Person on tax records and/or any other records We may reasonably request.

Weekly Earned Income does not include rent, royalties, investment income, passive income, estate and trust income or unearned income regardless of the Insured Person's active involvement in generating said forms of income, or any other income not derived directly from the Insured Person's occupational activities.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligibility

A person is eligible for insurance under this Policy when He meets the definition of Eligible Person shown in the *Schedule of Benefits.* An Eligible Person may be insured under only one covered class, even though He may be eligible under more than one covered class.

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Insured Person resulting from a change in benefits provided by this Policy or a change in the Insured Person's covered class will take effect on the date of such changes.

Policy Effective Date

The Company agrees to provide Accident insurance benefits described in this Policy in consideration of the Policyholder's application and payment of the Premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page.

Termination of Insurance

Insurance for the Insured Person will end on the earliest of:

1. the date the person is no longer in an Eligible Class;
2. the end of the period for which the last premium is made; or
3. the date this Policy ends.

Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earlier of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable benefit limit or maximums, as shown in the *Schedule of Benefits*, have been paid.

TERRITORY

This insurance applies worldwide.

COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits section or Conditions of Coverage section:

1. an Insured Person being in, entering, or exiting any aircraft: owned, leased or operated by the Policyholder or on the Policyholder's behalf; or operated by an employee of the Policyholder or Organization's behalf;
2. an Insured Person riding as a passenger in, entering, or exiting any aircraft while acting or training as a pilot or crew member. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency;
3. an Insured Person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions or medical or surgical treatment thereof. This exclusion does not apply to an Insured Person's bacterial infection caused by an Accident or by Accidental consumption of a substance contaminated by bacteria;
4. an Insured Person participating in military action while in active military service with the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority;
5. if the government of Canada has imposed any trade or economic sanctions prohibiting insurance of any Accident, Accidental Bodily Injury or Loss; or there is any other legal prohibition against providing insurance of any Accident, Covered Injury or Covered Loss.

CLAIM PROVISIONS

Beneficiary

An Insured Person has the right to designate a beneficiary. All beneficiary designations must be:

1) in writing;
2) filed with the Policyholder; and
3) provided to Us at the time of claim or at such other time as We may require.

If more than one person is named as beneficiary, the interests of each will be equal unless the Insured Person has specified otherwise. The share of any beneficiary who does not survive the Insured Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Insured Person dies while benefits are payable to Him, the Company may make direct payment to the first surviving class of the following classes of persons:

1. Spouse;
2. child or children;
3. parents;
4. siblings; or
5. estate of the Insured Person.

With respect to Insured Persons living in Quebec, the beneficiary designation of a Spouse is irrevocable, unless otherwise stipulated. Any other beneficiary is revocable.

Claim Forms

The Company or its designated authorized agent will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the Company received notice of claim, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made. The notice should include the Insured Person's name, the Policyholder's name and the Policy Number. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

Notice of Claim

Written notice of claim must be given to the Company or its designated authorized agent within 30 days after the occurrence or commencement of the Insured Person's Covered Loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company or its designated authorized agent, with information sufficient to identify the Insured Person, is deemed notice to the Company.

Payment of Claims

Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person's beneficiary as described in the Beneficiary Provision and these Claim Provisions.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable)

the Insured Person suffering the loss. If an Insured Person dies before all payments due have been made, the amount still payable will be paid to His beneficiary as described in the Beneficiary Provision.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to a parent, guardian, or other person actually supporting Him. If the payee has no legal guardian for His property, a payment not exceeding $5,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges liability to the extent of the payment made.

Time of Payment of Claims

Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid within 30 working days after receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Conditional Claim Payment

If the Insured Person incurs expenses for Covered Injuries and in Our opinion a third party may be liable, the Company will pay benefits if the Insured Person first agrees in writing to refund the lesser of:

1. the amount the Company actually paid for such expenses; and
2. the amount actually received from the third party, regardless of whether the amount is for such expenses, and the third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, if the third party's liability is satisfied in an amount less than the benefits paid under this Policy, the Company will pay the difference.

Legal Actions

No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought after expiry of the applicable statute of limitations from the time proof of loss is required to be furnished under this Policy.

Any legal action brought against Us in connection with or relating to this policy, regardless of whether framed in contract or in tort, shall without exception be brought and determined exclusively in the courts of the province in which this contract was delivered to the Policyholder.

In no case will We be liable for benefits that are not payable under the terms of this Policy or that exceed the applicable Benefit Amounts or limits of insurance of this Policy.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Ontario *Limitations Act, 2002*.

To the extent that the Policy is subject to the *Insurance Act of British Columbia, Alberta, or Manitoba*, the following provision applies:

Valuation and Currency

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act*.

All premiums, limits, Deductibles, benefits and other amounts under this Policy are expressed and payable in the lawful money of Canada. If judgment is rendered, settlement is denominated or another element of Loss under this policy is stated in a currency other than Canada, payment under this Policy shall be made at the rate of exchange published in the *Globe and Mail* on the date the judgment becomes final or payment of the settlement or other element of Loss is due.

Physical Examination And Autopsy

The Company, at its own expense, has the right and opportunity to examine the Insured Person when and as often as the Company may reasonably require while a claim is pending and to make an autopsy in case of death, where it is not prohibited by law.

Proof of Loss

Written proof of loss must be furnished to the Company within 30 days after the date of the Covered Loss. In the case of a claim for loss of time for disability, written proof of such loss must be furnished to the Company within 90 days after the commencement of the period for which the Company is liable. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as may reasonably be required. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to furnish proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

Governing Law

It is agreed that any interpretation of the coverage afforded in this Policy, including by reference any terms, conditions and provisions contained herein, will be governed by the laws of the province in Canada in which this Policy is issued.

For the purposes of the Insurance Companies Act (Canada), this document was issued in the course of AXIS Reinsurance Company (Canadian Branch)’s insurance business in Canada.

Subrogation

The Company has the right to recover all payments including future payments, which the Company has made, or will be obligated to pay in the future, to the Insured Person from anyone liable for the Covered Loss. If the Insured Person recovers from anyone liable for the Covered Loss, the Company will be reimbursed first from such recovery to the extent of the Company’s payments to the Insured Person. The Insured Person agrees to assist the Company in preserving its rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by the Company.

To the extent that the Policy is subject to the laws of Quebec, if the Insured Person has only received partial indemnification of his total loss by the coverage afforded under this Policy, the Insured Person will have priority over the Company to be reimbursed by amounts recovered from anyone found liable for the Covered Loss up to an amount corresponding to the uninsured and outstanding balance of the Insured Person's total loss.

ADMINISTRATIVE PROVISIONS

Cancellation

The Company or the Policyholder may cancel this Policy by giving the other party 31 days advance written or authorized electronic notice. Any premium rate guarantee will not affect the Company's or the Policyholder's right to cancel this Policy.

If a premium is not paid when due, the Company will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the Premium Rate Table.

Cancellation does not affect a claim for a Covered Loss when the Covered Accident occurs before the cancellation date.

Grace Period

A grace period of 31 days will be provided for the payment of any premium due after the first Premium Due Date. During the grace period, the Policy shall continue in force, unless the Policyholder has given written notice of discontinuance in advance of the Premium Due Date and in accordance with the terms of this Policy. If the required premium is not paid during the grace period, coverage will terminate on the last day of the grace period. The Policyholder will be liable for the payment of a pro rata premium for the time the Policy was in force during the grace period.

Other Coverage With This Company

If the insured person is covered under more than one similar policy issued by Us, the total benefits payable will not exceed those payable under the policy which provides the greatest benefit.

Premiums

Premium rates are expressed in, and premiums are payable in, the lawful money of Canada. The Company will provide notifications of premiums due or premium changes, to the most current address in Our files, to the Policyholder.

Premium Payment

The total premium paid by the Policyholder is the sum of premiums for all Insured Persons. The initial premium is due on the Policy Effective Date and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the Premium Rate Table, unless the Policyholder and the Company agree to another mode of premium payment. Premiums are paid at the Company's Home Office or to the Company's authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premium, except as provided in any applicable Grace Period section.

Premium Rate Changes

The Company may change premium rates at the end of any Policy Term or any premium rate guarantee period with at least 31 days advance notice to the last known address of the Policyholder. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

The Company may change the premium rate during a Policy Term or during any applicable premium rate guarantee period if any one of the following occurs:

1. the terms of this Policy change;
2. coverage is reinstated following failure to pay premium during the Grace Period;

3. a change in any provincial or local law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this Policy.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit

The Company will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

Reinstatement

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are a written application of the Policyholder satisfactory to the Company and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

GENERAL PROVISIONS

Addition of New Insured Persons

All Insured Persons added to the Classes of Eligible Persons in the *Schedule of Benefits* are eligible for insurance under this Policy.

Arbitration

In the event of a dispute under this policy, either We, an Insured Person, or in the event of Loss of Life, an Insured Person's beneficiary, may make a written demand for arbitration. In that case, We and an Insured Person, or in the event of Loss of Life, an Insured Person's beneficiary, will each select an arbitrator. The two arbitrators will select a third. If they cannot agree within fifteen (15)] days, then either We, an Insured Person, or in the event of Loss of Life, an Insured Person's beneficiary, may request that the choice of arbitrator be submitted to the superior court of the province in the province of an Insured Person's principal residence. The arbitration will be held in the province of an Insured Person's principal residence.

Each participant shall bear the cost for arbitration and shall share equally in the cost of the umpire and the proceedings.

Assignment

The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if the Company receives it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person’s debts unless contrary to law.

Certificates

Where required by law, the Company will provide a certificate of insurance for delivery to the Insured Person. Each certificate will set forth a statement as to the insurance coverage to which the Insured Person is entitled, and to whom the insurance benefits are payable, and a statement as to any family member, Spouse or dependent’s coverage. If family members or dependents are included in the coverage, the insurer need only issue one certificate to each family unit.

Clerical Error

A person’s coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, the Company will adjust the premium fairly.

Conformity with Statutes

This policy is governed by the laws of the province in which it is delivered to the Policyholder and the laws of Canada applicable therein. Any terms of this policy which are in conflict with the applicable statutes, laws, or regulations of the jurisdiction in which this policy is delivered are amended to conform to such statutes, laws, or regulations.

Entire Contract; Changes Allowed

The Policy and any attached papers make up the entire contract between the Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any Insured Person will be considered representations and not warranties. No written statement made by an Insured Person will be used in any contest unless a copy of the statement is furnished to the Insured Person or, in the event of the death or incapacity of the Insured Person, to His beneficiary or personal representative.

No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Examination of the Policy

This Policy will be available for inspection at the Policyholder's office during regular business hours.

Incontestability

The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, misrepresentation or fraud.

However, the Company may contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

Informational and Advertising Material

The Policyholder and its representatives must gain Our prior written approval of all material used for advertising and solicitation relating to this Policy, regardless of the medium in which such material appears. We will not be responsible for any increase in payment or any changes in insurance resulting from such materials that have not been approved by Us.

Misstatement of Fact

If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Noncompliance with Policy Requirements

Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.

Policy Changes

No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. The Company may agree with the Policyholder to modify a plan of benefits without the Insured Person's consent.

Records

The Policyholder or its authorized Administrator will maintain the records of the Insured Person's insurance under this Policy. The Company will be permitted to examine the Policyholder's records relating to the insurance under this Policy at any reasonable time. The Policyholder is acting as an agent of the Insured Person for transactions relating to this insurance. The actions of the Policyholder will not be considered the actions of the Company.

Replacement of a Contract of Group Insurance

Where this Policy replaces another contract of group insurance on some or all of the Insured Persons, the designation of an Insured Person, the Insured Person's representative, and the Insured Person's beneficiaries to whom money is payable under the replaced contract will apply to the Policy.

Replacement of a Previous Group Accident Insurance Contract in Quebec

To the extent that the Policy is subject to the laws of Quebec:

If the Policy replaces another group accident insurance contract, that had provided comparable coverage for all or part of the group of Insured Persons, the following provisions will apply:

a) a person insured under the former contract may not be excluded from the Policy or be denied benefits solely because of a pre-existing condition limitation that did not apply or exist under the former contract, or because the person is not at work when the Policy came into force; and

b) every person insured under the former contract is an Insured Person under the Policy on the termination of the former contract if the cessation of insurance was only due to such termination and if the person belongs to a class of Eligible Persons under the Policy.

Reporting Requirements

The Policyholder or its authorized agent must report all of the following to the Company by the Premium Due Date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated; and
4. additional information required by the Company.

The Company may, at the Company's sole discretion, waive reporting of any information specified above.

Workers' Compensation

This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Conditions on Expiry or Cancellation in Quebec

To the extent that the Policy is subject to the laws of Quebec:

The expiry or cancellation of this Policy may not be set up against a Covered Loss based on death, mutilation arising from an accident, disability, or sickness that occurred while the Policy is in force.

The Company will continue to compensate an Insured Person for any salary loss qualifying for coverage under the Policy if the Insured Person is still disabled after the Policy expires. The Company is not bound to compensate the Insured Person if the disability recurs after the expiry of the Policy and the Insured Person has not been disabled for more than 180 days.

CONDITIONS OF COVERAGE

MEMBERS COVERAGE

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs any time while insured by this Policy.

The Covered Loss must take place while:

1. the Insured Person is off duty from the Policyholder; and
2. the Insured Person is not participating in a Covered Activity of the Policyholder.

Exclusions Exclusions that apply to this Condition of Coverage are in the Common Exclusions Section.

MEMBERS & FAMILY COVERAGE

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs any time while insured by this Policy.

The Covered Loss must take place while:

1. the Insured Person is off duty from the Policyholder; and
2. the Insured Person is not participating in a Covered Activity of the Policyholder.

Exclusions Exclusions that apply to this Condition of Coverage are in the Common Exclusions Section.

DESCRIPTION OF BENEFITS

This Description of Benefits Section describes the Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits.* Please read these and the Common Exclusions section in order to understand all of the terms, conditions and limitations applicable to these Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Losses

The Company will pay the Benefit Amount for any one of the Covered Losses listed in the *Schedule of Benefits,* subject to all applicable conditions and exclusions*,* if the Insured Person suffers a loss as a result of a Covered Injury within the applicable time period specified in the *Schedule of Benefits.*

If the Insured Person sustains more than one Covered Loss as a result of the same Covered Accident, the total of Benefits the Company will pay will not exceed the Principal Sum.

Exposure and Disappearance

If by reason of an Accident occurring while an Insured Person's coverage is in force under this Policy, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a Covered Loss for which an Accidental Death or Accidental Dismemberment Benefit is otherwise payable under the Policy, the Covered Loss will be covered under the terms of this Policy.

If the body of an Insured Person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a Conveyance in which the Insured Person was an occupant while covered under this Policy, then it will be deemed, subject to all other terms and provisions of this Policy, that the Insured Person has suffered an Accidental Death that would have been payable under the Policy.

Definitions

For purposes of this Benefit:

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.
Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.
Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.
Loss of a Thumb or Index Finger of either Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
Loss of Toes means complete Severance through the metatarsalphalangeal joint.
Severance means complete separation and dismemberment of the part from the body.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

PARALYSIS BENEFIT
The Company will pay the Benefit Amount shown in the *Schedule of Benefits* for that type of Paralysis, subject to all conditions and exclusions, if an Insured Person suffers Paralysis as a result of a Covered Accident. If the Insured Person suffers more than one type of Paralysis as a result of the same Covered Accident, only one amount, the largest, will be paid.

Definitions For the purposes of this Benefit:

Paralysis/Paralyzed means Quadriplegia, Paraplegia, Hemiplegia or Uniplegia that is expected to last for a continuous period of 12 months or more from the earlier of the date of the Covered Accident causing paralysis or the date of the diagnosis. “Quadriplegia” means the complete and irreversible paralysis of both upper and lower limbs. “Paraplegia” means the complete and irreversible paralysis of both lower limbs or both upper limbs. “Hemiplegia” means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.

BRAIN DAMAGE BENEFIT
The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Injury that results in Brain Damage. The benefit will be payable if all of the following conditions are met:

1. Brain Damage begins within 30 days from the date of the Covered Injury;
2. the Insured Person is hospitalized for treatment of Brain Damage within the first 30 days following the Covered Injury;
3. Brain Damage continues for 12 consecutive months;
4. a Physician determines that as a result of Brain Damage, the Insured Person is permanently Totally Disabled at the end of the 12 consecutive month period.

The benefit will be paid in one lump sum at the beginning of the 13th month following the date of the Covered Injury if Brain Damage continues longer than 12 consecutive months.

The Maximum Benefit Amount for Brain Damage will be the percentage of the Insured Person’s Principal Sum shown in the *Schedule of Benefits*.

Definitions For purposes of this benefit:

Brain Damage means physical damage to the brain that causes an Insured Person’s inability to perform, without assistance, at least three (3) Activities of Daily Living.

Activities of Daily Living (ADL) means the following activities:

Bathing - the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment;

Dressing - the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;

Toileting - the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;

Transferring - the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment;

Eating - the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment; and

Continence - the ability to voluntarily maintain control of bowel and/or bladder function or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

COMA BENEFIT
The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person suffers a Covered Accident that results in a Coma, within the applicable time period specified in the *Schedule of Benefits.*

If an Insured Person dies within 365 days after the Covered Accident, then We will pay a lump sum equal to the Insured Person's Principal Sum, less any Benefit Amount for Coma already paid.

Definitions For purposes of this Benefit:

Coma means a profound state of unconsciousness from which the Insured Person is not likely to be aroused through powerful stimulation. The Coma must begin within 30 days of the Covered Accident, continue for 30 consecutive days and must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Accident.

VISION IMPAIRMENT BENEFIT
If an Insured Person suffers a vision impairment due to a Covered Accident, the Company will pay a Vision Impairment Benefit for each impaired eye. The amount of the Vision Impairment Benefit for each eye shall be the product of the Percentage of Vision Impairment Principal Sum corresponding to the Degree of Vision Impairment as shown in the *Schedule of Benefits*, multiplied by the Principal Sum shown in the *Schedule of Benefits*.

If an Insured Person's sight was less than 20/20 before the Covered Injury the Company will measure the vision impairment based upon the additional impairment measured after the Covered Injury. Loss of Sight means the permanent, irrecoverable loss of the entire sight in that eye.

TEMPORARY TOTAL DISABILITY WEEKLY INCOME BENEFIT
The Company will pay weekly Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, to the Insured Person whose Total Disability results from, and within the number of days specified in the *Schedule of Benefits* of, a Covered Injury. Disability benefits will begin when a Totally Disabled Insured Person satisfies the Benefit Elimination/Waiting Period shown in the Schedule of Benefits and will end on the earliest of the date He:

1. dies;
2. is no longer Totally Disabled;
3. fails to provide Us with certification by a Physician that He remains Totally Disabled;
4. reaches the end of the Maximum Benefit Period shown in the *Schedule of Benefits*.

Benefits are based on a 7-day week. Any Disability Benefit payable for less than a full week will be pro-rated.

The Weekly Benefit Amount for Temporary Total Disability shall be subject to the following conditions:

1) the Weekly Benefit Amount for Temporary Total Disability shall be excess of any collectible benefits under any Other Plan; and
2) the total payments to the Insured Person for Temporary Total Disability from all sources, including the Weekly Benefit Amount for Temporary Total Disability and any other benefits, as stated in 1) above, shall not exceed the Insured Person’s Prior Weekly Earned Income. If the total payments to the Insured Person from any other valid and collectible benefits under any Other Plan meet or exceed the Insured Person’s Prior Weekly Earned Income, then the minimum Weekly Benefit Amount for Temporary Total Disability will be payable to the Insured Person by Us.

Once the Insured Person is eligible to receive Temporary Disability Weekly Income Benefits, separate periods of Total Disability will be considered one continuous period of Disability if:

1. they result from the same Covered Injury; and
2. they are separated by no more than 14 consecutive days, unless due to separate and unrelated causes.

Definitions For purposes of this Benefit:

Temporary Total Disability or **Totally Disabled** means as a direct and sole result of a Covered Injury, an Insured Person:

1. is not able to perform the substantial and material duties of his or her regular occupation; and
2. has a condition which is medically determined, by a Physician, to be continuous; and
3. requires the continuous care of a Physician, during and immediately after the Elimination Period.

BEREAVEMENT BENEFIT

We will reimburse Bereavement Expenses for charges incurred by the Insured Person's Spouse and Dependent Children for grief counselling by a Professional Counsellor, up to the Benefit Amount shown in the Schedule of Benefits, if Covered Injury causes the Insured Person's Loss of Life. The Benefit Amount for Bereavement Expense is payable in addition to any other applicable Benefit Amounts payable under this policy.

CHILD CARE EXPENSE BENEFIT

We will reimburse Child Care Expenses up to the Benefit Amount for Child Care Expense, shown in the *Schedule of Benefits*, if a Covered Injury causes an Insured Person's covered Loss of Life. The Benefit Amount for Child Care Expense is payable in addition to any other applicable Benefit Amounts payable under this policy.

This insurance applies only if the Insured Person has a Dependent Child under the age of 13 years for whom Child Care Expenses are initially incurred within 1 year of an Insured Person's covered Loss of Life.

We will reimburse Child Care Expenses for each eligible Dependent Child. However, Our total payment will not exceed the Maximum Benefit Amount for Child Care Expense shown in the *Schedule of Benefits*, regardless of the number of Dependent Children for whom payment is made.

Payments shall be paid to the natural person who incurs such expenses for the Dependent Child.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian if the child is a minor, at the end of each year up to the Maximum Benefit Period shown in the *Schedule of Benefits*.

DEPENDENT CHILD EDUCATION EXPENSE BENEFIT

If an Insured Person suffers a Covered Injury and a death benefit is payable under this Policy, the Company will pay expenses incurred by each Dependent Child for tuition, fees, books, room and board, transportation and any other costs payable directly to a school, or approved and certified by the school, up to the Maximum Annual Benefit Amount shown in the *Schedule of Benefits***.**

In order to qualify for benefits, a qualifying Dependent Child must:

1. be a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the Insured Person's death or begin studies as a full-time student at an accredited school of higher learning within 2 years of the Insured Person's death and before reaching the limiting age shown in the Dependent Child definition; and
2. continue His education as a full-time student in such accredited school for four (4) consecutive years.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian if the child is a minor, at the end of each year up to the Maximum Benefit Period shown in the *Schedule of Benefits*. The Company must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a benefit is payable will begin on the first of the month following the date the Insured Person died, if the surviving Dependent Child was a full-time student on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date He begins studies in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

FAMILY TRAVEL EXPENSE BENEFIT
If, as a result of a Covered Injury, an Insured Person is confined to a Hospital not less than fifty (50) kilometres from their permanent city of residence and the attending Physician recommends the personal attendance of an Immediate Family Member, we will reimburse for Covered Family Travel Expenses. The most the Company will pay under this benefit is the Maximum Family Travel Expense Benefit Amount shown in the *Schedule of Benefits*.

Definitions For purposes of this Benefit:

Family Travel Expense means actual costs incurred by an Immediate Family Member for temporary lodging, transportation and meals while travelling to and from visits with an Insured Person.

FUNERAL EXPENSE BENEFIT
The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, for burial or cremation of the Insured Person who dies from a Covered Injury and an Accidental Death Benefit is payable under this Policy.

HOME ALTERATION OR VEHICLE MODIFICATION BENEFIT
The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if a Covered Injury requires an Insured Person to incur expenses for Home Alteration or Vehicle Modification. The expenses for Home Alteration or Vehicle Modification must be incurred within twenty four (24) months after the Covered Injury. The Benefit Amount for Home Alteration or Vehicle Modification is payable if:

1) a Physician certifies that the Home Alteration or Vehicle Modification is needed to accommodate a physical disability of an Insured Person;
2) the Home Alteration or Vehicle Modification is made by people experienced in such Home Alteration or Vehicle Modification;
3) the Home Alteration or Vehicle Modification is in compliance with any applicable laws or requirements for approval by the appropriate governmental authority in the jurisdiction where the services are rendered; and
4) the Home Alteration or Vehicle Modification expenses do not exceed the usual level of charges for similar alterations and modifications in the jurisdiction where the expenses are incurred.

We will also reimburse expenses incurred for hiring of transportation services necessary to accommodate the physical disability of the Insured Person.

The Benefit Amount for Home Alteration and Vehicle Modification is payable to the natural person who incurs the expense. The Benefit Amount for Home Alteration and Vehicle Modification is payable in addition to any other applicable Benefit Amounts under this policy. In no event will Our total payments for Home Alteration and Vehicle Modification exceed the Maximum Benefit Amount for Home Alteration and Vehicle Modification shown in the *Schedule of Benefits*.

Definitions For purposes of this Benefit:

Home Alteration means changes to an Insured Person's primary residence that are necessary to make the residence accessible and habitable for such Insured Person.

Private Passenger Automobile means a four-wheeled motor vehicle with a maximum seating capacity of nine (9) people, manufactured, designed and registered as a private passenger vehicle for travel on public roads.

Vehicle Modification means changes, including but not limited to installation of equipment, to a Private Passenger Automobile that are necessary to make such Private Passenger Automobile accessible to or driveable by an Insured Person.

HOME HEALTH CARE EXPENSE BENEFIT
The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person requires Home Health Care at home for treatment of a Covered Injury. The attending Physician must prescribe such services and must certify that if these services were not available, the Insured Person would have to be hospitalized to receive the necessary care, treatment, and services following a Hospital Stay of at least 15 days. The expenses that are the subject of the Benefit Amount for Home Health Care must be incurred within 18 months after the Covered Injury. The Benefit Amount for Home Health Care is payable on an excess basis up to the Usual and Customary Charges. We will determine the charges for Home Health Care. We will then reduce that amount by amounts already paid or payable by any valid and collectible benefits under any Other Plan.

Definitions For purposes of this Benefit:

Home Health Care means Medically Necessary services provided and billed by the Home Health Agency. Such services must be prescribed and supervised by a Physician in accordance with a medical treatment.

Home Health Agency means an entity engaged in arranging and providing nursing services, home health services or other therapeutic and related services. The entity must be certified by a competent governmental authority in the jurisdiction where the services are rendered, as meeting the requirements for home health agencies.

IDENTIFICATION EXPENSE BENEFIT
The Company will pay up to the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if Covered Injury causes an Insured Person's covered Loss of Life and

1. causes an Insured Person’s Loss of Life, within one year of the Accidental Bodily Injury;
2. the presence of an Immediate Family Member is requested by the police or a similar governmental authority; and
3. the Loss of Life occurs not less than one hundred and fifty (150) kilometres from the Insured Person’s city of permanent residence.

The Identification Benefit Amount is payable to the natural person who incurs the expense.

PARENT CARE BENEFIT
The Company will pay the Benefit Amount shown in the *Schedule of Benefits* for Parent Care, as shown in the *Schedule of Benefits*, if a Covered Injury causes an Insured Person's covered Loss of Life. The Benefit Amount for Parent Care is payable in addition to any other applicable Benefit Amounts payable under this Policy.
Payments shall be paid to the natural person who incurs such expenses for the Dependent Parent.

One time payment(s) will be made to each qualifying Dependent Parent or to the parent's legal guardian of the parent, up to the Maximum Benefit shown in the *Schedule of Benefits*. Our total payment will not exceed the Maximum Benefit Amount for Parent Care shown in the Policy Schedule of Benefits, regardless of the number of Dependent Parents for whom payment is made.

PSYCHOLOGICAL THERAPY EXPENSE
The Company will reimburse up to the Benefit Amount shown in the *Schedule of Benefits* for Psychological Therapy Expense, if a Covered Injury causes an Insured Person to suffer a Covered Loss resulting in a Physician's determination that Psychological Therapy is required for:

1) such Insured Person; or
2) a Dependent who is also an Insured Person under the policy at the time of the Covered Injury.

The Benefit Amount for Psychological Therapy Expense will be paid:

1) to the natural person who incurs the expense; and
2) in addition to any other applicable Benefit Amounts under this policy.

The Benefit Amount for Psychological Therapy Expense will be paid until the earlier of the date on which:

1) the total Benefit Amount for Psychological Therapy Expense, shown in the Schedule of Benefits, has been paid; or
2) two (2) years have elapsed from the date of a Covered Loss.

Definitions For purposes of this Benefit:

Psychological Therapy means Medically Necessary counselling for a mental or nervous disorder by a Physician, whether on an out-patient basis, in a Hospital or any other medical facility licensed to provide such treatment.

Psychological Therapy Expense means Usual and Customary Charges for Psychological Therapy.

REHABILITATION EXPENSE BENEFIT
The Company will pay up to the Benefit Amount shown in the *Schedule of Benefits* for Rehabilitation Expense up to the Benefit Amount for Rehabilitation Expense, shown in the *Schedule of Benefits*, if Covered Injury causes an Insured Person to suffer a Covered Loss which:

1) prevents an Insured Person from performing all the duties of such Insured Person's regular occupation; and
2) requires such Insured Person to obtain Rehabilitation, as determined by a Physician approved by Us.

The Benefit Amount for Rehabilitation Expense is payable in addition to any other applicable Benefit Amounts under this policy. We will pay the Benefit Amount for Rehabilitation Expense to the natural person who incurs the expense.

We will pay the Benefit Amount for Rehabilitation Expense until the earlier of the date on which:

1) the total Rehabilitation Expense Benefit shown in the *Schedule of Benefits* has been paid; or
2) two (2) years have elapsed from the date of the Covered Injury.

PARENT CARE BENEFIT
The Company will pay the Benefit Amount shown in the *Schedule of Benefits* for Parent Care, as shown in the *Schedule of Benefits*, if a Covered Injury causes an Insured Person's covered Loss of Life. The Benefit Amount for Parent Care is payable in addition to any other applicable Benefit Amounts payable under this Policy.
Payments shall be paid to the natural person who incurs such expenses for the Dependent Parent.

One time payment(s) will be made to each qualifying Dependent Parent or to the parent's legal guardian of the parent, up to the Maximum Benefit shown in the *Schedule of Benefits*. Our total payment will not exceed the Maximum Benefit Amount for Parent Care shown in the Policy Schedule of Benefits, regardless of the number of Dependent Parents for whom payment is made.

PSYCHOLOGICAL THERAPY EXPENSE
The Company will reimburse up to the Benefit Amount shown in the *Schedule of Benefits* for Psychological Therapy Expense, if a Covered Injury causes an Insured Person to suffer a Covered Loss resulting in a Physician's determination that Psychological Therapy is required for:

1) such Insured Person; or
2) a Dependent who is also an Insured Person under the policy at the time of the Covered Injury.

The Benefit Amount for Psychological Therapy Expense will be paid:

1) to the natural person who incurs the expense; and
2) in addition to any other applicable Benefit Amounts under this policy.

The Benefit Amount for Psychological Therapy Expense will be paid until the earlier of the date on which:

1) the total Benefit Amount for Psychological Therapy Expense, shown in the Schedule of Benefits, has been paid; or
2) two (2) years have elapsed from the date of a Covered Loss.

Definitions For purposes of this Benefit:

Psychological Therapy means Medically Necessary counselling for a mental or nervous disorder by a Physician, whether on an out-patient basis, in a Hospital or any other medical facility licensed to provide such treatment.

Psychological Therapy Expense means Usual and Customary Charges for Psychological Therapy.

REHABILITATION EXPENSE BENEFIT
The Company will pay up to the Benefit Amount shown in the *Schedule of Benefits* for Rehabilitation Expense up to the Benefit Amount for Rehabilitation Expense, shown in the *Schedule of Benefits*, if Covered Injury causes an Insured Person to suffer a Covered Loss which:

1) prevents an Insured Person from performing all the duties of such Insured Person's regular occupation; and
2) requires such Insured Person to obtain Rehabilitation, as determined by a Physician approved by Us.

The Benefit Amount for Rehabilitation Expense is payable in addition to any other applicable Benefit Amounts under this policy. We will pay the Benefit Amount for Rehabilitation Expense to the natural person who incurs the expense.

We will pay the Benefit Amount for Rehabilitation Expense until the earlier of the date on which:

1) the total Rehabilitation Expense Benefit shown in the *Schedule of Benefits* has been paid; or
2) two (2) years have elapsed from the date of the Covered Injury.

Physician means a licensed health care provider practicing within the scope of his or her license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:

1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's spouse;
3. a person living in the Insured Person's household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Policy Term means the time period defined for the Policyholder shown on the *Policy Schedule of Benefits.*

Prior Weekly Earned Income means The greater of the Insured Person's:

a. Weekly Earned Income at the time the disability starts; or
b. average Weekly Earned Income for the period of twelve (12) weeks prior to the start of disability for which a claim is made; or
c. average Weekly Earned Income for the period of one year prior to the start of disability for which a claim is made.

Psychological Therapy means Medically Necessary counselling for a mental or nervous disorder by a Physician, whether on an out-patient basis, in a Hospital or any other medical facility licensed to provide such treatment.

Rehabilitation means treatment other than Psychological Therapy intended to prepare an Insured Person for work in any Gainful Occupation, including an Insured Person's regular occupation that is:

1) provided by a therapist licensed, registered, or certified to perform such treatment; or
2) provided in a Hospital or other facility, which is licensed to provide such treatment.

Spouse means a person of the same or opposite sex who:

1) is legally married to and cohabits with the Insured Person, or if there is no such person,
2) is a person who qualifies as a common law or domestic partner under the provisions of any applicable federal, provincial, territorial, or local law.

Usual and Customary Charge means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

Weekly Earned Income means the Insured Person's weekly earnings from all sources for regular, over-time and shift differential wages. Weekly Earned Income shall be substantiated by pay stubs, Canadian Individual Income Tax Return, other employment records, tax records and/or any other records which we may reasonably request. The Weekly Earned Income must be verified by the Insured Person's employer and/or tax records.

If the Insured Person is self-employed, we will compute Weekly Earned Income from the amount reported by the Insured Person on tax records and/or any other records we may reasonably request.

Weekly Earned Income does not include rent, royalties, investment income, passive income, estate and trust income or unearned income regardless of the Insured Person's active involvement in generating said forms of income, or any other income not derived directly from the Insured Person's occupational activities.

The Description of Benefits listed below are sample wordings. Actual wording may vary based on approved wording from state Insurance Regulators. Please see Proposed Coverage Offering 11A-11H for state/province and group eligibility availability by state.

DESCRIPTION OF BENEFITS

This Description of Benefits Section describes the Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits.* Please read these and the Common Exclusions sections in order to understand all of the terms, conditions and limitations applicable to these Benefits.]

[ACCIDENTAL DEATH BENEFIT

Covered Loss

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if the Insured Person dies directly and independently of all other causes from a Covered Loss **[**within the applicable time period specified in the *Schedule of Benefits***]**.

Exclusions

Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Losses

The Company will pay the Benefit Amount for any one of the Covered Losses listed in the *Schedule of Benefits,* subject to all applicable conditions and exclusions*,* if the Insured Person suffers a Covered Loss **[**within the applicable time period specified in the *Schedule of Benefits.***]**

[If the Insured Person sustains more than one Covered Loss as a result of the same Covered Accident, the Company will pay the Benefit for the Covered Loss for which the largest benefit is payable.**]**

[If the Insured Person sustains more than one Covered Loss as a result of the same Covered Accident, the total of Benefits the Company will pay will not exceed the Principal Sum.**]**

[If a Covered Loss causes the Insured Person's death the Company will pay for Accidental Death and any other Covered Losses will not exceed the **[**Principal Sum, Accidental Death Benefit, largest Benefit payable for a Covered Loss**]** **[**unless death results from **[**Heart Failure.**]]**

Exposure and Disappearance

If by reason of an Accident occurring while an Insured Person's coverage is in force under this Policy, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a Covered Loss for which an Accidental Death or Accidental Dismemberment benefit is otherwise payable under the Policy, the Covered Loss will be covered under the terms of this Policy.

If the body of an Insured Person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a Conveyance in which the person was an occupant while covered under this Policy, then it will be deemed, subject to all other terms and provisions of this Policy, that the Insured Person has suffered an Accidental Death that would have been payable under the Policy.

Definitions

For purposes of this benefit:

[Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.**]**

[Loss of Use of a Hand or Foot means total loss of all ability to move the hand or foot, within **[**30-365 days**]** of a Covered Accident, that continues for **[**6-24 months**]** and is expected to continue for the remainder of the Insured Person's lifetime.**]**

[Loss of Sight means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.**]**

[Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.**]**

[Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.**]**

[[Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand] means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).**]**

[Loss of Toes means complete Severance through the metatarsalphalangeal joint.**]**

[Heart Failure means death because the heart ceases to beat due to failure of the heart to maintain adequate circulation of blood **[**provoked by participation in a Covered Activity.**]]**

[Coma means a profound state of unconsciousness from which the Insured Person is not likely to be aroused through powerful stimulation. The Coma must begin within 10 days of the Covered Loss, continue for 30 consecutive days and must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Loss.**]**

[Brain Death means irreversible unconsciousness, resulting directly and independently of all other causes from and within 10 days of a Covered Accident, manifested by both total loss of brain function and complete absence of electrical activity of the brain, even though the heart is still beating.**]**

[Severance means complete separation and dismemberment of the part from the body.**]**

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[ACCIDENTAL SEVERE BURN AND DISFIGUREMENT BENEFIT

The Company will pay the Benefit Amount, shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Severe Burn due to a Covered Accident.

A Physician must determine that the burn satisfies all of the following:
1. involves the minimum percentage shown in the *Schedule of Benefits*; and
2. be classified as shown in the *Schedule of Benefits*; and

3. results in disfigurement or loss of physical abilities.

Definitions

For purposes of this benefit:

Severe Burn/Severely Burned means cosmetic disfigurement of at least **[**20% to 80%**]**of the surface of a body area due to a Covered Injury that is a **[**third-degree, full-thickness burn, as determined by a Physician. The Company has the right, at its own expense, to have the Physician's determination verified by a Physician of the Company's choice. A third degree, full-thickness burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

[First-degree burn means burn that is limited to redness (erythema), a white plaque and minor pain at the site of the covered injury. These burns involve only the epidermis. **]**

[Second-degree burns means a manifest as erythema with superficial blistering of the skin, and can involve more or less pain depending on the level of nerve involvement. Second-degree burns involve the superficial (papillary) dermis and may also involve the deep (reticular) dermis layer. **]**

Exclusions

Exclusions that apply to this benefit are in the *Common Exclusions* Section.**]**

[ACCIDENT MEDICAL [AND EMERGENCY SICKNESS] BENEFIT

Covered Expenses and any applicable **[**Aggregate Deductible and specific benefit**]** Deductibles are shown in the *Schedule of Benefits.*

Other Health Care Plan Benefits

When another Health Care Plan provides benefits in the form of services rather than cash payments, the Company will consider the reasonable cash value of such service in determining whether any Deductible has been satisfied, or any amount by which any benefit provided by this Policy will be reduced.

[Primary Medical Expense

The Company will pay Covered Expenses without regard to any Health Care Plan the Insured Person may have, after any applicable Deductible and Aggregate Deductible is satisfied.**]**

[Primary Excess Medical Expense

The Company will pay Covered Expenses, up to the Primary Excess Benefit shown in the *Schedule of Benefits* after the Insured Person satisfies any Deductible, **[**and**] [**after the Policy Aggregate Deductible has been satisfied,**]** without regard to any other Health Care Plan the Insured Person may have. The Company will then pay Covered Expenses**[**:

1. after the Insured Person satisfies any Deductible; and
2.**]** only when they are in excess of amounts payable by any other Health Care Plan, whether or not claim has been made for benefits it provides.

The Company will pay benefits without regard to any Coordination of Benefits provisions in such Health Care Plan.

Any Covered Expenses payable under this provision will be reduced by the Other Health Care Plan Reduction Percentage shown in *Schedule of Benefits***]** or the amount the Health Care Plan would have paid had its services or facilities been utilized**]** if:

1. the Insured Person has coverage under another Health Care Plan; and
2. the Other Health Care Plan is an HMO, PPO or similar arrangement; and

3. the Insured Person does not use the facilities or services of the HMO, PPO or similar arrangement.

Covered Expenses payable will not be reduced for emergency treatment within 24 hours after a Covered Accident which occurred outside the geographic service area of the HMO, PPO or similar arrangement.**]**

[Full Excess Medical Expense

The Company will pay Covered Expenses:
1. after the **[** Aggregate Deductible has been satisfied and**]** the Insured Person satisfies any Deductible; and
2. only when they are in excess of amounts payable by any Other Health Care Plan whether or not claim has been made for benefits it provides.

The Company will pay benefits without regard to any Coordination of Benefits provision in such Health Care Plan.

Any Covered Expenses payable under this provision will be reduced by the Other Health Care Plan Reduction Percentage shown in *Schedule of Benefits* if the amount the Health Care Plan would have paid had its services or facilities been utilized if:
1. the Insured Person has coverage under another Health Care Plan; and
2. the Other Health Care Plan is an HMO, PPO or similar arrangement; and
3. the Insured Person does not use the facilities or services of the HMO, PPO or similar arrangement.

Covered Expenses payable will not be reduced for emergency treatment within 24 hours after a Covered Loss which occurred outside the geographic service area of the HMO, PPO or similar arrangement.

[Limited Primary Medical Expense

The Company will pay Covered Expenses, up to the Limited Primary Benefit shown in the *Schedule of Benefits*:
[1. after the Policy Aggregate Deductible has been satisfied; and**]**
[2. the Insured Person satisfies any Deductible; and**]**
3. subject to the Non-Duplication of Benefits provision in the *Limitations* Section.

No further benefits are paid until the Insured Person has: (a) satisfied any Deductible; and (b) incurred a total of the Excluded Covered Expenses shown in the *Schedule of Benefits*. The Company will pay Covered Expenses described in this Policy in excess of the Excluded Covered Expenses, without regard to any Other Health Care Plan the Insured Person may have.**]**

[Limited Primary Excess Medical Expense

The Company will pay Covered Expenses, up to the Limited Primary Benefit shown in the *Schedule of Benefits*:
[1. after the Policy Aggregate Deductible has been satisfied; and**]**
[2. the Insured Person satisfies any Deductible; and**]**
3. subject to the Non-Duplication of Benefits provision in the *Limitations* Section.

No further benefits are paid until the Insured Person has: (a) satisfied any Deductible; and (b) incurred a total of the Excluded Covered Expenses shown in the *Schedule of Benefits*. The Company will pay Covered Expenses described in this Policy in excess of the Excluded Covered Expenses, only when they are in excess of amounts paid by any Other Health Care Plan regardless of any Coordination of Benefits provision it may contain.

Any Covered Expenses payable under this provision will be reduced by the Other Health Care Plan Reduction Percentage shown in the *Schedule of Benefits or* the

amount the Other Health Care Plan would have paid had its services or facilities been utilized if:

1. the Insured Person has coverage with another Health Care Plan; and
2. the other Plan is an HMO, PPO or similar arrangement; and
3. the Insured Person does not use the facilities or services of the HMO, PPO or similar arrangement.**]**

Covered Expenses payable will not be reduced for emergency treatment within 24 hours after a Covered Accident which occurred outside the geographic service area of the HMO, PPO or similar arrangement.**]**

COVERED EXPENSES:

The Company will pay the benefits shown in the *Schedule of Benefits* for Covered Expenses incurred by the Insured Person, subject to all applicable conditions and exclusions, for treatment of a Covered Loss.

Benefits will be paid:

[1. when Covered Expenses incurred exceed any applicable **[** Aggregate and individual**]** Deductible **[**within the number of days from the date of the Covered Accident **[**or Emergency Sickness**]** specified in the *Schedule of Benefits***]***;* and**]**

[2. as long as the first expense has been incurred within the number of days specified in the *Schedule of Benefits*; and**]**

[3. until any applicable Benefit Period shown in the *Schedule of Benefits* has expired; and**]**

4. until the total of Covered Expenses paid equals any applicable Benefit Limit or Maximum Benefit shown in the *Schedule of Benefits*; and

[5. until Benefits paid equal the Maximum for Accident Medical Expense Benefits shown in the *Schedule of Benefits*.**]**

[In-Patient Hospital Services

Room and Board Expenses

The Company will pay for:

1. confinement in an intensive care unit**[**, up to the maximum daily benefit shown in the *Schedule of Benefits***]** for each day of such confinement;
2. any other confinement, **[**up to the maximum daily benefit shown in the *Schedule of Benefits***]** for each day of the Hospital Stay; and
3. **[**The Company will also pay Covered Expenses incurred for treatment of an Emergency Sickness.**]**

Hospital Miscellaneous Expenses

The Company will pay the Miscellaneous Expenses charged by a Hospital or ambulatory surgical center for Outpatient surgery. Hospital Miscellaneous Expenses include, but are not limited to, X-ray, laboratory, **[**in-Hospital physiotherapy,**] [**Nurse services,**] [**orthopedic appliances,**]**, pre-admission tests, and all necessary charges other than room and board, for services received during a Hospital Stay. **[**The Company will also pay Covered Expenses incurred for treatment of an Emergency Sickness.**]] [**Hospital Miscellaneous Expenses also include personal supplies and services, such as barber or beautician services and television when provided during a Hospital Stay.**]]**

[Ambulatory Medical Center

The Company will pay Covered Expenses incurred for medical or surgical treatment provided in a licensed facility providing ambulatory surgical or medical treatment that is not a Hospital or Physician's office.**]** . **[**The Company will also pay Covered Expenses incurred for Ambulatory Medical Center for treatment of an Emergency Sickness.**]]**

[Emergency Room Treatment

The Company will pay Covered Expenses incurred for Outpatient emergency room treatment performed in a Hospital, up to the Maximum Benefit shown in the

Schedule of Benefits. When emergency room treatment is immediately followed by admission to a Hospital, such treatment will be a Hospital Covered Expense. .**[**The Company will also pay Covered Expenses incurred for emergency room treatment of an Emergency Sickness.**]]**

[Physician Services

The Company will pay Covered Expenses incurred for Physician Services listed below.

[Surgery –

1. Covered Expenses charged for performing a surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure.**[** However, the Company will pay up to **[**50%-500%**]** of the benefit for a surgical procedure when more than one surgical procedure through different operating fields is performed during the same surgical session;**]** and

[2. Covered Expenses charged by an assistant surgeon assisting a Physician performing a surgical procedure.**]**

[3. Covered Expenses charged for treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including aftercare, which is given in the outpatient department of a Hospital or an ambulatory surgical center.**]**

[4. any braces, splints or other devices required after surgery to ensure proper healing.

[5. **[**the Company will also pay Covered Expenses incurred for treatment of an Emergency Sickness.**]]]**

[Use of Physician's Surgical Facilities – Covered Expenses charged for the use of the Physician's surgical facilities.**]**

always included when surgical services are included

[Second Opinion or Consultation – Covered Expenses charged by a Physician for a second surgical opinion, or consultation.**]**

[Physician's Assistant – Covered Expenses charged by a Physician's Assistant for other than pre- or post-operative care, second opinion or consultation:

1. for in-Hospital visits; and
2. for office visits.**]**

[Anesthesia and its Administration – Covered Expenses charged by a Physician for anesthesia and its administration.**]**

[In-Hospital or Office Visits – Covered Expenses charged by a Physician for other than pre- or post-operative care, second opinion or consultation:

1. for in-Hospital visits; and
2. for office visits.**]]**

[Out-Patient [X-Ray, CT Scan, MRI and Laboratory Tests]

The Company will pay Covered Expenses incurred for **[**X-ray **[**, except dental X-rays,**]**, CT Scans, MRI's, and laboratory tests**] [**The Company will also pay Covered Expenses incurred for treatment of an Emergency Sickness.**].]**

[Out-Patient Physiotherapy

The Company will pay Covered Expenses incurred for out-patient Physiotherapy. Physiotherapy means: **[** (a) acupuncture;
(b) microthermy; (c) chiropractic adjustment; (d) manipulation; (e) diathermy; (f) massage therapy; (g) heat treatment; and (h) ultrasonic treatment**].]**

[Out-Patient Nursing Services

The Company will pay Covered Expenses incurred for out-patient services rendered by a Nurse.**] [**The Company will also pay Covered Expenses incurred for treatment of an Emergency Sickness.**]**

[Ambulance Services

The Company will pay Covered Expenses incurred for **[**ground or air;**]** ambulance service to transport the Insured Person from the place where the Covered Loss or **[**or Emergency Sickness] occurred. **[**The Company will pay Covered Expenses incurred for **[**ground or air**]** ambulance transportation from the nearest medical facility to another appropriate medical facility, if a Physician specifies in writing that specialized care not available in the first facility to which the Insured Person was transported is necessary to treat His Covered Loss.**]]**

[Medical Equipment Rental

The Company will pay Covered Expenses incurred for rental or, if less, purchase of:

1. a wheelchair or Hospital bed; or
2. other medical equipment that has permanent or temporary therapeutic value for the Insured Person and that can only be used by the Insured Person. Permanent or temporary therapeutic value is solely determined by the Company. Examples of items that are not covered include, but are not limited to: computers, motor vehicles and modifications thereof, ramps and installation costs, **[**eyeglasses and hearing aids**].]**

[Medical Services and Supplies

The Company will pay Covered Expenses incurred for:

1. blood and blood transfusions, including processing and administration; and
2. cost and administration of oxygen and other gases.

[The Company does not pay for storage of blood for any reason.**]]**

[Dental Services

The Company will pay Covered Expenses incurred for dental treatment, including X-rays, for injury to a tooth:

1. with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and
2. for which pulpal tissues are healthy and intact; and
3. for which periodontal tissue shows little or no signs of active or chronic inflammation. For insurance review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth.

Covered Expenses include examinations, x-rays, restorative treatment, endodontics, oral surgery and initial braces required for treatment of a Covered Injury and treatment of gingivitis resulting from trauma.

Covered Expenses must be incurred within the Benefit Period shown in the *Schedule of Benefits*. If there is more than one way to treat a dental problem, The Company will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.**]**

[An Insured Person who is insured for Extended Dental Benefits under this Policy will not also be covered for dental benefits under this provision.

[Prescription Drugs

The Company will pay the Covered Expenses incurred for drugs that: (a) can only be obtained through a Physician's written prescription; and (b) are approved for such prescription use by the Federal Drug Administration (FDA). The Company will also pay Covered Expenses incurred for drugs that meet (a) all of the above and are prescribed by a Physician for therapeutic use not specifically approved by the FDA. The Covered Expense for a prescription drug is limited to the cost of a generic drug unless: (1) substitution of a generic drug is prohibited by law; or (2) no generic drug is available; or (3) the Insured Person's Physician specifically requests that a non-generic drug be dispensed to the Insured Person. **[**The Company will also pay Covered Expenses incurred for treatment of an Emergency Sickness.**]]**

[[Eyeglasses, Contact Lenses,Hearing Aids] [Artificial Dental Devices]

The Company will pay Covered Expenses incurred for eyeglasses and contact lenses **[**or hearing aids**] [**artificial dental devices**] [**when purchase and fitting is necessary to treat a Covered Loss and/or repair or replacement, when damaged in a Covered Loss or repair or replacement, for which **[**the Covered Person**]** has incurred other Covered Expenses**]]**.

[[Artificial Limbs, Eyes and Larynx]

The Company will pay Covered Expenses incurred for **[**initial**] [**artificial limbs, eyes and larynx**]**, including fitting. **[**The Company does not pay for repair or replacement of **[**artificial limbs, eyes or larynx.**]]]**

[Home Health Care

The Company will pay Covered Expenses incurred for care and treatment rendered to the Insured Person by a Home Health Care Agency, for the maximum number of visits, as shown in the *Schedule of Benefits*, for:

1. part-time nursing care by or supervised by a registered graduate nurse;
2. part-time Home Health Aide service which consists of caring for the patient;
3. physical, speech and occupational therapies when indicated in conjunction with the Insured Person's discharge placement through a Rehabilitation Facility approved by the attending Physician and by the Company;
4. nutritional counseling;
5. medical social services by a qualified social worker licensed by the jurisdiction in which services are rendered.

Home Health Care services must be preceded by a Minimum Hospital Stay and must begin within the specified number of consecutive days of discharge from a Hospital or Extended Care or Rehabilitation Facility. The Minimum Hospital Stay and the number of days of confinement within which Home Health Care must begin are shown in the *Schedule of Benefits*.**]**

[Rehabilitation Facility

The Company will pay Covered Expenses incurred for physical and occupational rehabilitation provided to the Insured Person. Treatment must be rendered by a Physician or provided at a Physician's direction, at a Rehabilitation Facility.**]**

[Extended Care Facility

The Company will pay Covered Expenses incurred by the Insured Person for treatment of a Covered Loss in an Extended Care Facility. Confinement in such Facility must:

1. be preceded by a Minimum Hospital Stay; and
2. begin within the number of consecutive days of a Minimum Hospital Stay, as specified in the *Schedule of Benefits*; and
3. include treatment for which a Physician visits the Insured Person at least once every 30 days.**]**

[Expanded Medical Benefit of Sports Conditions

The Company will pay Covered Expenses incurred for the treatment of the Sports Conditions shown in the *Schedule of Benefits* if they are aggravated by the Insured Person's participation in a **[**Covered Activity**][**Covered Hazard**]**.

Termination of Benefit
This benefit will terminate at 12:01 A.M. Standard Time on the day after the team of which the Insured Person is a member has played its last game, including post-season tournament play.**]**

[Heart and Circulatory Conditions

The Company will pay Covered Expenses incurred for the treatment of the Heart and Circulatory Conditions shown in the *Schedule of Benefits* if they occur and are manifested during a Covered Activity.

[Hemorrhoid Benefit

The Company will pay Covered Expenses incurred for the treatment of the Hernia shown in the *Schedule of Benefits* provided such Hemorrhoid is surgically repaired while the Insured Person coverage is in force under this Policy provided the Covered Loss occurs and manifested during a Covered Activity.

[Hernia Benefit

The Company will pay Covered Expenses incurred for the treatment of the Hernia shown in the *Schedule of Benefits* provided such Hernia is surgically repaired while the Insured Person coverage is in force under this Policy provided the Covered Loss occurs and manifested during a **[**Covered Activity**][**Covered Hazard**]**.

[Mental and Nervous Disorders

Hospital Expenses

The Company will pay Covered Expenses incurred for treatment of the Insured Person's mental and nervous disorder that results directly and independently of all other causes from a Covered Loss, when the Insured Person is an in-patient in the Hospital. Each out-patient treatment provided in a Hospital will count as one-half day of in-patient treatment for the purpose of determining the Insured Person's Maximum Number of Days shown in the *Schedule of Benefits.* One-half day will be subtracted from the Insured Person's Maximum Number of Days for each out-patient treatment.

Physician Expenses

The Company will pay Covered Expenses incurred for the treatment of mental and nervous disorders when treatment is rendered by a Physician. Benefits will be limited to **[**one – five**]** treatment**[**s**]** per day.**]**

[HMO/PPO Denial Benefit

The Company will pay Covered Expenses incurred, up to the maximum shown in the Schedule of Benefits, when benefits are denied or reduced by an HMO or PPO plan because services provided to treat an Covered Loss were:

1. rendered by an Non-Preferred Provider;
2. or received outside of the network's service area.

If benefits are reduced rather than denied by an HMO or PPO for the reasons described above, the Company will pay an amount equal to the Covered Expense incurred less the amount paid by the HMO or PPO.**]**

[Pre-Existing Injury Benefit

The Company will pay Covered Expenses incurred, up to the maximum shown in the Schedule of Benefits, for the treatment of an Aggravation or re-injury of a Pre-existing Injury.

[Definitions

For purposes of this Benefit:

[Emergency Sickness means an illness or disease diagnosed by a Physician which:

1. causes a severe or acute symptom that, if not provided with immediate treatment, would reasonably be expected to result in serious deterioration of the Insured Person's health or place His life in jeopardy; and
2. first manifests itself suddenly and unexpectedly while the Insured Person is [covered under this policy] [participating in a Covered Activity or Covered Hazard.**]]**

[HMO – Health Maintenance Organization means any organized system of health care that provides health maintenance and treatment services for a fixed sum of money agreed and paid in advance to the provider of service.**]**

[PPO – Preferred Provider Organization means an organization offering health care services through designated health care providers who agree to perform these services at rates lower than Non-Preferred Providers.**]**

[Non-Preferred Provider means any Hospital, Physician, or other provider of health care services which is not a member of an HMO or PPO plan.**]]**

[LIMITATIONS AND] EXCLUDED EXPENSES

[Limitation For Motor Vehicle Accidents

Benefits will be paid for Covered Expenses incurred for treatment of Covered Injuries that result directly and independently of all other causes from a Covered Loss that occurred while the Insured Person was riding in or driving a Motor Vehicle. Benefits will not exceed the Benefit Limit shown in the *Schedule of Benefits*.**]**

[Limitation for Treatment of Spine

Benefits will be paid for Covered Expenses incurred for treatment of the spine, by manual or mechanical means, up to the Benefit Limit shown in the *Schedule of Benefits*. This limitation will not apply to surgical treatment which is performed under general anesthesia.**]**

[Limitation for Burn Treatment

Benefits will be paid for Covered Expenses incurred for treatment of burns, up to the Benefit Limit shown in the *Schedule of Benefits*. If the Insured Person suffers third degree burns in addition to second degree burns, the Benefit Limit shown for third degree burns will apply for all burns suffered in the same Covered Accident.**]**

[Limitation for Contributory School and/or Sports Coverage

If benefits are payable for any Covered Loss under this Policy and under another blanket accident insurance policy issued by the Company for which **[**the School, Policyholder, Subscriber**]** pays the entire premium:

1. benefits will be payable first under that policy; and
2. the total of benefits payable under both policies will not exceed the maximum benefit amount in the policy that provides the greater maximum.**]]**

[Pre existing condition

means an illness, disease, injury or other condition of the Insured Person that in the **[**2, 6 ,12 ,18 ,24, 36**]** month period before the Insured Persons coverage became effective under the Policy:

1. was treated by a Physician or treatment had been recommended by a Physician.
2. required taking prescribed drugs or medicines, or
3. **[**first manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinarily prudent person to seek diagnosis.**]]**

Excluded Expenses

The following will not be considered Covered Expenses unless coverage is specifically provided.

1. **[**blood, blood plasma,**]** **[**or blood storage,**]** except expenses by a Hospital for processing or administration of blood.
2. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Loss.
3. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States.

[4. **[**examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, orthopedic braces, or orthotic devices**].]**

5. treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.
6. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
7. rest cures or custodial care.
8. Repair or replacement of existing dentures, partial dentures, braces or bridgework.
9. personal services such as television and telephone or transportation.

[10. orthopedic appliances used mainly to protect an Injury so that **[**the Covered Person**]** can take part in **[**interscholastic, intercollegiate and club sports**].]**
[11. expenses payable by any automobile insurance policy without regard to fault.**]**
[12. services or treatment provided by an infirmary operated by **[**the Policyholder; Subscriber**].]**
[13. treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the Covered Activity.**]**
[14. treatment of HIV/AIDS, meaning Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome or AIDS Related Complex (ARC) regardless of the means by which it was acquired.**]**
[15. treatment or service provided by a private duty nurse.**]**
[16. repair or replacement of existing **[**artificial limbs, eyes and larynx**].]**
[17. Treatment of Hernia of any kind. Hernia means a rupture or protrusion of an organ or part through connective tissues or through a wall of a cavity in which it is normally enclosed.**]**
[18. chiropractic treatment **[**or Physiotherapy**].]**
[19. treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Loss, unless the Company has received a written medical release from His Physician.**]**
20. charges for any article of clothing intended for use more than once.
[21. treatment of an injury resulting from or contributed to by **[**frostbite,**] [**fainting or seizures, or**] [**heatstroke or heat exhaustion**].]**

Other Exclusions that apply to this Benefit are in the Common Exclusions Section.

[In no event will the Company's total payments for the Insured Person or exceed the Maximum Benefit Amount for the Accident Medical Expense shown in the Schedule of Benefits.**]**

[AIRCRAFT [OWNED] [LEASED] [OPERATED] [OR] [CONTROLLED] BENEFIT

The Company will pay Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a **[**Covered Loss**]** that occurs during travel or flight in, including getting in or out of, any Aircraft that is **[**owned,**] [**leased, **[**operated**] [**or controlled**]**by **[**the Policyholder, Subscriber or any of its subsidiaries or affiliates**]**.

A record of eligible Aircraft will be maintained by **[**the Policyholder, Subscriber, Employer**]** and provided to us at our request. **[**An eligible Aircraft leased by **[**the Policyholder, Subscriber, Employer**]** includes one of the same types or class specified in the leasing contract. **[**An Aircraft substituted for an eligible Aircraft will also be eligible if it is as similar to the original Aircraft in design and seating capacity as is available, and the original Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction. **[**An Aircraft controlled by **[**the Policyholder, Subscriber, Employer**]** is one available for its use for 10 or more consecutive days or 15 days during any calendar year.**]]**

Exclusions Exclusions that apply to this coverage are in the Common Exclusions Section.**]**

[AIRCRAFT PILOT [CREW] [AND] [PASSENGERS] BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss that occurs while the Insured Person is flying as a licensed pilot **[**or

member of the crew**][**or Passenger**]** of an Aircraft and meets all of the following requirements:

1. Has submitted a completed Pilot Data History form and has been accepted for Pilot Coverage by the Company;
2. Maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by the Company;
3. Completes and maintains a combined minimum of 400 scheduled hours of military, private or professional logged flight hours;
4. Is flying as a pilot **[**or member of the crew**]** of an Aircraft traveling on or transacting business for **[**the Policyholder or Subscriber**]**. All trips must have been authorized in advance by **[**the Policyholder, Subscriber**]**;
5. Is flying as a pilot **[**or member of the crew**]** of an Aircraft described below *or* on a list of eligible Aircraft maintained by **[**the Policyholder, Subscriber**]**;
6. Is flying as a pilot **[**or member of the crew**]** of an Aircraft that is not **[**owned,**]** **[**leased,**]** **[**operated**]** or **[**controlled**]** by **[**the Policyholder, Subscriber**]**;
7. Is not giving or receiving flight instruction.

[Description of Aircraft Covered

A record of eligible Aircraft will be maintained by **[**the Policyholder, Subscriber, and Employer**]** and provided to us at our request. An eligible Aircraft leased by **[**the Policyholder, Subscriber, and Employer**]** includes one of the same types or class specified in the leasing contract.

[An Aircraft substituted for an eligible Aircraft will also be eligible if it is as similar to the original Aircraft in design and seating capacity as is available, and the original Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction. An Aircraft controlled by **[**the Policyholder, Subscriber, and Employer**]** is one available for its use for 10 or more consecutive days or 15 days during any calendar year.**]**

[Replacement Aircraft Coverage

If any Designated Aircraft in the Policy Condition of Coverage(s) that designate which aircraft are covered)**]** is replaced with a newly acquired aircraft, the replacement aircraft may also be considered a Designated Aircraft for the purposes of such Condition of Coverage (s) only if the replacement aircraft: 1) has a current, valid Airworthiness Certificate in the same class as the replaced aircraft: and 2) has the same or lesser passenger and crew member seat capacity as the replaced aircraft.

Exclusions

Exclusions that apply to this coverage are in the Common Exclusions Section.**]**

[BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits* for counseling sessions, subject to all applicable conditions and exclusions, when the Insured Person **[**and/or Immediate Family Member *or* Fellow Participant**]** requires bereavement and trauma counseling because of an Accidental Death or Covered Accident under this policy. Such counseling must meet all of the following conditions:

1. covered bereavement and trauma counseling expenses must be incurred within [one year] from the date of the Covered Loss;
2. the expense is charged for a bereavement or trauma counseling session for the Insured Person**[**and/or one or more of His Immediate Family Members *or* Fellow Participants**]**;
3. counseling is provided under the care, supervision or order of a Physician; and
4. a charge would have been made if no insurance existed.

[Definitions For purposes of this benefit:

Fellow Participant means an Insured Person, other than the Insured Person who suffered a Covered Loss, who was present at or participating in the same Covered Activity and as a result suffered trauma requiring counseling treatment.**]**

Exclusions Exclusions that apply to this benefit are in the *Common Exclusions* Section.

[BOMB SCARE, BOMB SEARCH OR BOMB EXPLOSION BENEFIT

The Company will pay the Benefit Amount shown *Schedule of Benefits* if the Insured Person suffers a Covered Loss and all of the following conditions are met:

1. the Insured Person is on the [Policyholder's] [Subscriber's**]** premises when the Covered Loss occurs;
2. the Covered Loss is caused by or results from a Bomb Scare, Search or Explosion, as defined below;
3. the Insured Person is an authorized participant of a team or squad engaged in a Bomb Search or related activity; and
4. **[**the Policyholder, Subscriber**]** authorizes the Insured Person's participation and sanctions the Search.

Definitions For purposes of this benefit:

Bomb means any real or dummy explosive device placed with intent to damage, scare, or cause injury.

Scare means any real or false report of a Bomb on the premises of **[**the Policyholder, Subscriber**]**.

Search means any organized search for a reported Bomb.

Explosion means any detonation of a Bomb on **[**the Policyholder's, Subscriber's**]** premise which appears to have been intended to cause injury or unlawful property damage, whether or not the presence of the Bomb was reported before detonation. It does not include any act of declared or undeclared war in the United States of America or Canada, or acceptance of known explosives as cargo.

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section. **]**

[BULLETPROOF VEST BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if the Insured Person who is Age 18 or older is on official duty for the [Policyholder] [Subscriber**]**, is shot while wearing a Bulletproof Vest and:

1. the Bulletproof Vest fails to prevent the bullet's penetration through the vest; and
2. such penetration results, directly and independently of all other causes, in a Covered Loss.

Definitions For purposes of this benefit:

Bulletproof Vest means a protective vest designated as Threat Level II-A, Threat Level II or Threat Level III-A manufactured by a vendor designated by the [Policyholder] [Subscriber**]** and purchased not more than five years before the Covered Accident.

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[BURIAL AND CREMATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, for burial or cremation of the Insured Person who dies from a Covered Injury and an Accidental Death Benefit is payable under this Policy.

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[CATASTROPHIC CASH BENEFIT

The Company will pay benefits, as shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if the Insured Person suffers **[**Paralysis,**] [**Coma**]**, **[**Brain Death**] [**the loss of 2 of the 6 Activities of Daily Living**] [**Loss of Use**] [**or two or more Covered Losses**]**, as described below. The Insured Person to who a Catastrophic Cash benefit is payable will be deemed Totally Disabled. If the Insured Person suffers more than one of these as a result of the same Covered Accident [or Emergency Sickness], the largest available benefit will be payable.

The first Catastrophic Cash Benefit, as shown in the *Schedule of Benefits*, becomes payable when the Insured Person has met each of the following **[**one to three conditions**][** Paralysis,**] [**Coma**]**, **[**Brain Death**] [**the loss of **[**1-6**]** of the 6 Activities of Daily Living**] [**Loss of Use**] [**or two or more Covered Losses**]** and remains alive. **[**Each additional periodic payment becomes payable at the end of the period for which the last payment was made, as long as Paralysis continues and the Insured Person remains alive. The amount of each periodic payment and the period for which they are made are shown in the *Schedule of Benefits.* The Company will terminate benefits if Physician certification of Paralysis is not provided when requested.**]]**

[Coma means a profound state of unconsciousness from which the Insured Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Loss, unless the state of unconsciousness results from administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Loss.

The Insured Person's Coma must:

1. Begin within the period shown in the *Schedule of Benefits;* and
2. Continue for the period shown in the *Schedule of Benefits*; and
3. Be expected, as certified by a Physician, to continue for an indefinite period or end, leaving the Insured Person expecting, as certified by a Physician, to remain Totally Disabled for the remainder of His life.

The first Catastrophic Cash Benefit, as shown in the *Schedule of Benefits,* becomes payable when the Insured Person has met each of the three conditions specified above and remains alive. **[**Each additional periodic payment thereafter becomes payable at the end of the period for which the last payment was made, as long as the Insured Person remains Comatose or Totally Disabled and alive. The amount of each periodic payment and the period for which they are made are shown in the *Schedule of Benefits*. The Company will terminate benefits if Physician certification of Coma or Total Disability is not provided when requested.**]]**

[Brain Death means irreversible unconsciousness with:

1. Total loss of brain function; and
2. Complete absence of electrical activity of the brain, even though the heart is still beating.

Brain Death must:

1. Occur within the period shown in the *Schedule of Benefits;* and
2. Be diagnosed by a Physician.

The first Catastrophic Cash Benefit, as shown in the *Schedule of Benefits*, becomes payable when the Insured Person has met both of the conditions specified above and remains alive. **[**Each additional periodic payment becomes payable at the end of the period for which the last payment was made, as long as Brain Death continues and the Insured Person remains alive. The amount of each periodic payment and the period for which they are made are shown in the *Schedule of Benefits.* The Company will terminate benefits if Physician certification of Brain Death is not provided when requested.**]]**

[Covered Losses: **Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.

[Loss of Use of a Hand or Foot means total loss of all ability to move the hand or foot, within 180 days of a Covered Accident, that continues for 12 months and is expected to continue for the remainder of the Insured Person's lifetime.**]**

Loss of Sight means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

[Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).**]**

The first Catastrophic Cash Benefit, as shown in the *Schedule of Benefits,* becomes payable on the date the Insured Person suffers loss of two or more Covered Losses, and while the Insured Person remains alive. **[**Each additional periodic payment thereafter becomes payable at the end of the period for which the last payment was made, as specified in the *Schedule of Benefits,* as long as the Insured Person has not recovered**[** the use of sight, speech or hearing, and remains alive.**]** The amount of each periodic payment and the period for which they are made are shown in the *Schedule of Benefits*. The Company will terminate benefits if Physician certification of continuing Loss of Sight, Speech or Hearing Loss, or any other Covered Loss is not provided when requested.**]]**

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[CATASTROPHIC TOTAL DISABILITY BENEFIT

The Company will pay the Monthly Disability Benefits, as shown in the *Schedule of Benefits,* less any Other Income Benefits, when the Insured Person is Totally Disabled or Partially Disabled from a Covered Loss*,* subject to all applicable conditions and exclusions. The Company will pay Initial Monthly Benefits during the Initial Disability Period. The Company will pay Subsequent Monthly Benefits

as shown in the *Schedule of Benefits* during the first 12 months of the Subsequent Disability Period. During each 12-month period after the first Subsequent Disability Period, this Benefit will increase by the Benefit Increase Percentage shown in the *Schedule of Benefits.*

Total Disability Benefits

Total Disability Benefits will begin with the month the Company determines the Insured Person is Totally Disabled. The Insured Person's Total Disability must begin within the time period shown in the *Schedule of Benefits*.

Termination of Total Disability Benefits

Total Disability Benefits will end on the earliest of the date:

1. The Insured Person is no longer Totally Disabled;
2. Monthly Disability Benefits have been paid for the Benefit Period shown in the *Schedule of Benefits*;
3. The Insured Person fails to provide proof of continuing Total Disability when requested;
4. The Insured Person is entitled to and is receiving Partial Disability Benefits;
5. The Insured Person dies.

The Company will pay Partial Disability Benefits shown in the *Schedule of Benefits*, without regard to any increase in Total Disability Benefits paid during the Subsequent Benefit Period. Partial Disability Benefits will increase by the Benefit Increase Percentage at the end of each 12-month period during which Partial Disability Benefits were paid. Partial Monthly Disability Benefits will be reduced by one-half of the after-tax monthly compensation the Insured Person earns in excess of the Monthly Earnings Maximum shown in the *Schedule of Benefits*.

[Partial Disability Benefits

Partial Disability Benefits will be paid to the Insured Person who is Partially Disabled following a period of Total Disability for which the Company paid Total Disability Benefits, if:

1. Partial Disability results from the same Covered Loss which caused the immediately preceding period of Total Disability; and
2. The Insured Person was receiving benefits for Total Disability immediately prior to the period of Partial Disability.

Resumption of Partial Disability Benefits

The Insured Person who recovers from Partial Disability and again becomes Partially Disabled can resume receiving Partial Disability Benefits, subject to the following conditions:

1. the Insured Person's Average Gross Monthly Earnings must fall below the Maximum Monthly Earnings for each month in the Earnings Period shown in the *Schedule of Benefits*; and
2. the loss of Average Gross Monthly Earnings must result directly from the same Covered Loss.

Partial Disability Benefits will be payable, during the Benefit Period shown in the *Schedule of Benefits,* for the period that the Partial Disability continues.

Termination of Partial Disability Benefits

Benefits for Partial Disability will end on the earliest of the date:

1. the Insured Person is no longer Partially Disabled;
2. Total and Partial Monthly Disability Benefits have been paid for the Benefit Period shown in the *Schedule of Benefits*;
3. the Insured Person's Average Gross Monthly Earnings exceeds the Partial Disability Maximum for the Earnings Period;
4. the Insured Person fails to provide proof of continuing Partial Disability when requested;
5. the Insured Person dies.**]**

[Other Income Benefits

The Insured Person for whom Total or Partial Disability Benefits are payable under this Policy may be eligible for Other Income Benefits. If so, the Company will reduce Monthly Disability Benefits by the amounts of such Other Income Benefits.

Other Income Benefits include:

1. any amounts received or assumed to be received by the Insured Person under:
   a. the Canada and Quebec Pension Plans;
   b. the Railroad Retirement Act;
   c. any local, state, provincial or federal government disability or retirement plan or law payable for Injury provided as a result of any employment the Insured Person may have;
   d. any sick leave or salary continuation plan;
   e. any work loss provision in mandatory No-Fault auto insurance;
   f. any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury arising out of work with His employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted;
2. any Social Security disability or retirement benefits the Insured Person or any third party receives or is assumed to receive on His own behalf;
3. any Retirement Plan benefits funded by the Insured Person's employer. Retirement Plan means any defined benefit or defined contribution plan sponsored or funded by the Insured Person's employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan;
4. any proceeds payable under any individual, franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, the Company will pay for its pro rata share of the total claim. Pro rata share means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies;
5. any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.**]**

[Increases in Other Income Benefits

Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating the Insured Person's Disability Benefits after the first reduction is made for any Other Income Benefits.**]**

[Assumed Receipt of Benefits

The Company will assume the Insured Person is receiving benefits for which He is eligible from sources listed above as Other Income Benefits. The Company will reduce the Insured Person's Monthly Disability Benefits by the amounts from Other Income Benefits the Company estimates are payable to the Insured Person.

The Company will waive Assumed Receipt of Benefits if the Insured Person:

1. provides satisfactory proof of application for Other Income Benefits; and
2. signs a reimbursement agreement; and

3. provides satisfactory proof that all appeals for Other Income Benefits have been made unless the Company has determine that further appeals are not likely to succeed; and
4. submits satisfactory proof that Other Income Benefits were denied.

The Company will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until the Insured Person actually receives them.

The Company may limit the waiver of Assumed Receipt of Benefits at our discretion.**]**

The Company will reduce Total Disability Benefits by the amount of any Average Gross Monthly Earnings for work the Insured Person performs while Totally Disabled. The Company will reduce Partial Disability Benefits by **[**one-half**]** of the Insured Person's Average Gross Monthly Earnings that exceed the Monthly Earnings Maximum per month.

Definitions

For purposes of this Benefit:

Average Gross Monthly Earnings means the Insured Person's rate of pay per month as reported by His employer for work performed for the employer. **[**It does not include commissions, overtime, bonus or additional compensation or pay for more than the Insured Person's regular scheduled work week.**]** Average Gross Monthly Earnings also include self-employment income.

Partial Disability or **Partially Disabled** means the inability of the Insured Person who was engaged in an occupation before He became Totally Disabled, to perform all of the material duties of that occupation and to earn more than the Maximum Monthly Earnings shown in the *Schedule of Benefits*.

Total Disability or Totally Disabled means the Insured Person has suffered permanent loss of one or more of:
1. Speech;
2. Hearing in both ears;
3. Sight in both eyes;
4. Use of both arms;
5. Use of both legs;
6. Use of one arm and one leg; or
7. motor or cognitive function resulting from brain stem or other neurological injury; and that permanent loss results in the Insured Person's inability to:
   a. perform 2 of the 6 Activities of Daily Living including eating, transferring, dressing, toileting, bathing, and continence without human supervision or assistance; or
   b.. perform each and every duty of His occupation during the Initial Benefit Period; or
   c.. perform each and every duty of any business or occupation for which He is reasonably fitted by education, training or experience, during the subsequent Benefit Period.

Exclusions

Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[CHILD CARE CENTER BENEFIT

The Company will pay Benefit Amount shown in the *Schedule of Benefits* for the care of each surviving Dependent Child in a Child Care Center **[**after school program or summer camp**]** if an Accidental Death Benefit for the Insured Person

[Insured Spouse**]** is payable under this Policy and He is survived by one or more Dependent Children under Age 13; who

1. was enrolled in a Child Care Center on the date of the Accidental Death; or
2. enrolls in a Child Care Center within 365 days from the date of the Accidental Death.

This benefit will be payable to the surviving Spouse if the Spouse has custody of the child. If the surviving Spouse does not have custody of the Dependent Child, benefits will be paid to the Dependent Child's legally appointed guardian. Payments will be made at the end of each 12 month period that begins after the date of the Insured Person's death. A claim must be submitted to the Company at the end of each 12 month period **[**with proof of enrollment and attendance**]**. A 12 month period begins:

1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in 2. above, after the Insured Person's death; or
2. on the first of the month following the Insured Person's death, if the Dependent Child was enrolled in a Child Care Center before the Insured Person's death.

Each succeeding 12-month period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

[If there is no surviving Dependent Child at the time of the Insured Person's Covered Death, the Default Benefit shown in the *Schedule of Benefits* will be paid to the Insured Person's beneficiary.**]**

Definitions

For purposes of this benefit:

Child Care Center is a facility which:

1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis including [after school program and summer camp programs]

A Child Care Center does not include any of the following:

1. a Hospital;
2. the child's home; or
3. care provided during normal school hours while a child is attending grades one through twelve.

[Surviving Spouse will include the Insured Person and Insured Spouse.**]**

Exclusions

Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[CHILD SURVIVOR BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable condition and exclusions, if an Accidental Death Benefit for the Insured Person **[**Spouse**]** is payable under this Policy and He is survived by a covered Dependent Child.

If the Dependent Child was under the Age of majority at the time of the Insured Person's death, a Child Survivor Benefit, plus interest, will be paid in one lump sum to each surviving covered Dependent Child when He attains the age of majority. Interest will be compounded annually at a rate equal to the arithmetic average of the 52-week U.S. Treasury notes as published by a financial authority designated by the Company. If the covered Dependent Child dies before this

benefit is payable to Him, this benefit will then be payable to the Dependent Child's estate.

If a surviving covered Dependent Child is the Age of majority or over at the time of the Insured Person's death, the benefit will be payable in one lump sum when the Company receives the claim.

If there are no surviving Dependent Children at the time of the Insured Person's Accidental Death, a default benefit shown in the *Schedule of Benefits* will be paid to the Dependent [Spouse's beneficiary.

Benefits will not be paid if a claim is submitted to the Company more than one year after:

1. the Insured Person's death, or if earlier;
2. the child is no longer a Dependent Child, if He was under the Age of majority at the time of the Insured Person[Spouse's**]** death.

[Definitions For purposes of this benefit:

[Family Coverage means coverage in force under the Policy on an Insured's Eligible Dependents: 1) whom the Insured has elected to cover under the Policy; and (2) for whom premium has been paid.**]**

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[[COBRA] [MEDICAL] [DENTAL] [VISION] INSURANCE CONTINUATION EXPENSE BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if a surviving Spouse **[**or surviving Eligible Domestic Partner**] [**or a surviving Dependent Child**]** elects to continue group medical **[** dental**] [**or vision] insurance provided by the Employer of the Insured Person who died and benefits were payable under this Policy, subject to all applicable conditions and exclusions if all of the following conditions are satisfied:

1. the Insured Person's death results directly and independently of all other causes from a Covered Accident;
2. the Insured Person is survived by a Spouse **[**or surviving Eligible Domestic Partner**] [**or Dependent Child;**]]**
3. a Spouse**[** or Dependent Child **]**is also covered under a medical **[**or dental**] [**or vision**]** plan sponsored by the Insured Person's Employer at the time of His death;
4. a Spouse **[**or surviving Eligible Domestic Partner**] [**or Dependent Child**]** notifies the Company of His election, within 60 days of the Insured Person's death, to continue His existing coverage under group insurance plans sponsored by the Employer as permitted by state or federal continuation law.

This benefit, payable annually, equals premiums required to continue insurance described above, as long as the total of Insurance Continuation Benefits paid for a surviving Spouse or Dependent Child**]** do not exceed the Benefit Amount shown in the *Schedule of Benefits*. The benefit will be paid at the end of each year during which medical **[** dental**][** Vision**]** insurance is continued, if the Company receives the request for reimbursement and proof of premiums paid during that year. Benefits will continue to be paid until the earliest of the following dates:

1. the date a surviving Spouse **[**or surviving Eligible Domestic Partner**][**or surviving Dependent Child**]**is no longer eligible to continue medical **[**and/or dental**]** insurance coverage;
2. the date Insurance Continuation Expense Benefits paid total Benefit Amount shown in the *Schedule of Benefits;* and

3. the end of the Maximum Benefit Period.

Benefits are payable to the surviving Spouse or surviving Dependent Child, or the person who actually paid the premium on the surviving Spouse 's behalf, if other than the surviving Spouse .

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.

[COLLEGE EDUCATION EXPENSE BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, for the Insured Person to complete His degree or course of study at the School He was attending, or in which He was enrolled to attend, at the time of the Covered Loss that resulted in His Total Disability. The Insured Person must be receiving **[**Total Disability *or* Catastrophic Cash**]** Benefits provided by this Policy and must resume study within one year of the date of the Covered Accident and while He continues to receive Total Disability Benefits.

College Education Expenses College Education Expenses include expenses incurred for tuition, student fees, books and on-campus or off-campus room and board. If the Insured Person does not reside on-campus, the Company will pay an amount based on the lesser of the actual room and board cost and typical on-campus room and board rates. Tuition, student fees, books and on-campus room and board amounts will be obtained from the School's financial aid office. Benefits paid will be reduced by any scholarship or other financial aid the Insured Person receives.

Payment of Benefits Benefits will be paid directly to the School or other provider as payment is due.

Termination of Payments Payments will terminate on the earliest of:

1. the date the Insured Person completes the requirements for any degree or certificate of completion for a course of study; and
2. the end of the Benefit Period shown in the *Schedule of Benefits*; and
3. the date the Insured Person is no longer Totally Disabled; and
4. the date the Insured Person is no longer receiving Total Disability or Catastrophic Cash benefits; and
5. the date the Insured Person dies; and
6. the date any maximum benefit limit shown in the *Schedule of Benefits* is reached.

Exclusions Benefits will not be payable for any cost incurred by any Insured Person for modification or alteration of special accommodations necessitated by the Total Disability.

COMA BENEFIT

The Company will pay the Coma Benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person becomes comatose **[**as a result of an Emergency Sickness**]** or suffers a Covered Injury **[**or Emergency Sickness**]** that results in Coma, **[**within the applicable time period specified in the *Schedule of Benefits**]***

Definitions For purposes of this benefit:

Coma means a profound state of unconsciousness from which the Insured Person is not likely to be aroused through powerful stimulation. The Coma must begin within 30 days of the Covered Accident, continue for 30 consecutive days and must be diagnosed and treated regularly by a Physician. Coma does not

mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Loss.

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.

[COMMON CARRIER [PUBLIC CONVEYANCE] BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss that occurs while the Insured Person is riding as a fare-paying passenger in, entering or exiting the Common Carrier.

Benefits will be payable for a Covered Loss that occurs as a result of the Insured Person being struck by any Aircraft while at the airport before or after arrival of a flight that would have been covered; being struck by any train while at a train station before or after the arrival a train that would have been covered]; or being struck by any bus while at a bus depot before or after the arrival of a bus that would have been covered**]]**

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

CRISIS DEATH BENEFIT

The Company will pay Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if the Insured Person's death results within the applicable time period specified in the *Schedule of Benefits*, from another person's use of a gun or a knife to commit an act of violence while insurance under this Policy is in effect. Such an act of violence must occur

[1. on School premises during Normal School Hours**] [**; or
2. during a Covered Activity**][**Covered Hazard**]]**.*or*
[1. while the Insured Person is on the Employer's premises**]**; **[**and
2. while the Insured Person is performing normal duties of His job during regularly-scheduled work hours**]**.

[The Maximum Benefit Amount shown in the *Schedule of Benefits* will be divided equally among all Insured Persons if the benefit payable for each Insured Person multiplied by the number of benefits payable for any one Covered Loss would exceed that Maximum.**]**

[Definitions For purposes of this benefit:

[Normal School Hours means a scheduled period of instruction beginning one half hour before the first scheduled period of instruction of the day begins and ending one half hour after the last scheduled period of instruction of the day ends. If the Insured Person is serving a detention after Normal School Hours, the period is extended until one half hour after the end of the period of detention for that day.**]**

Exclusions Benefits will not be payable if:

[1. the act of violence occurs while the Insured Person is traveling to and from **[**School, or to and from a Covered Activity**]** *or*
[1. the act of violence occurs while the Insured Person is traveling to and from His regular place of employment**]**; or**]**

2. the act of violence is committed by as Immediate Family Member parent or sibling ; or
3. the Insured Person produces or obtains a gun or a knife during the incident and is killed, whether or not the Insured Person is acting in self defense.

Other exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[ELDER SURVIVOR BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if an Insured Person suffers an Accidental Death such that an Accidental Death benefit is payable under the Policy. The Company will pay a benefit to or on behalf of any Elder Dependent of the Insured Person on the date of the Insured Person's death if such Elder Dependent survives after the date of the Insured Person's death.

Definitions For purposes of this benefit:

Elder Dependent - means the Insured Person's parent, parent-in-law, grandparent, grandparent-in-law, great-grandparent or great-grandparent-in-law (whether natural, step or adoptive), if that person is primarily dependent on the Insured Person for support and maintenance.

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[ESCALATOR [INFLATION] BENEFIT

The Company will pay the Benefit Amount shown in *Schedule of Benefits*, subject to all applicable conditions and exclusions, for each Insured Person who remains continuously insured under the Policy The Benefit Amount will be increased on each anniversary of the Insured Person's Effective Date of Coverage under the Policy that occurs on or after the date this benefit becomes effective by a dollar amount equal to the percentage amount of the Principal Sum shown in the *Schedule of Benefits* that was in force on the Insured Person on**[** the later of: (1)**]** His Effective Date of Coverage under the Policy; or (2) the date this **[**Escalator**[[**Inflation**]** Benefit becomes effective. The increase will be a simple, not compound, increase. It will be applied for a maximum of **[**3 - 25**]** anniversaries, or until the Insured Person current Principal Sum has been increased by a total dollar amount equal to **[**10- 100**]**% of the Principal Sum that was in force on the Insured Person on the later of: (1) the Insured Person's Effective Date;and (2) the date this benefit becomes effective .

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[FELONIOUS ASSAULT AND VIOLENT CRIMEBENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss that occurs during a Felonious Assault or Violent Crime as described below. A police report detailing the Felonious Assault or Violent Crime must be provided before any benefits will be paid. **[**The Covered Loss must occur while the Insured Person is on the business or premises of **[**the Subscriber, Policyholder**].]**

Definitions For purposes of this benefit:

Felonious Assault means any willful and unlawful use of force by an individual against the Insured Person in connection with the commission, or attempted commission of robbery, theft, kidnapping, hostage taking, hijacking, assault, murder, manslaughter, riot, or insurrection. Such use of force must be a felony or equivalent of a felony under any country, state, territory or local statutory or common law applicable in the jurisdiction where the Covered Loss occurs.

Fellow Employee means a person employed by the same Employer as the Insured Person or by a [Policyholder][Subscriber] that is an affiliated or subsidiary corporation. It shall also include any person who was so employed, but whose employment was terminated not more than 45 days prior to the date on which the defined felonious assault/violent crime was committed.

Member of the Same Household means a person who maintains residence at the same address as the Insured Person.

Violent crime means violent crime that involves force or threat of force and is composed of four offenses: murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault.

Exclusions

Benefits will not be paid for treatment of any Covered Loss incurred during any:
1. Felonious Assault or Violent crime committed by the Insured Person; or
2. Felonious Assault or Violent crime committed upon the Insured Person by a Fellow Employee, Immediate Family Member, or Member of the Same Household.

Other exclusions that apply to this benefit are in the *Common Exclusions* Section.

[HEART AND CIRCULATORY MALFUNCTION

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person suffers a sudden heart and circulatory malfunction and the first symptoms of the malfunction are medically diagnosed while the Insured Person is covered under this Policy and within 24 hours of a **[**Covered Activity**] [**while in the Line of Duty. **]**

Definitions

For purposes of this coverage:

[Line of Duty means performing the professional responsibilities of a qualified individual for the position the Insured Person holds as set forth by the standards of the Policyholder.**]**

Exclusions

The benefits will not be payable if in the past year, the Insured Person was medically diagnosed as having, or received treatment for:
1. a heart or circulatory malfunction ;or
2. hypertension, angina or other heat or circulatory condition.

Other Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[HIV OCCUPATIONAL OR ASSIGNED DUTIES OR VOLUNTEER DUTIES ACCIDENT BENEFIT]

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss during the performance of **[**Occupational *or* Assigned Duties**]** and it results in the Insured Person acquiring and testing positive for Human Immunodeficiency Virus (HIV) antibodies within one year of the Covered Accident.

In order to receive this benefit, the Insured Person must satisfy all of the following:

1. submit an injury report to His Employer, including any report required for purposes of any applicable Workers' Compensation Law, within 96 hours of a Covered Accident that occurs during the performance of Occupational or[or Volunteer] Assigned Duties;
2. test negative for Human Immunodeficiency Virus (HIV) antibodies within 96 hours of such Covered Accident; and
3. test positive for Human Immunodeficiency Virus (HIV) antibodies in a subsequent Blood Test within one year of the date of the Covered Accident.

[If the Insured Person tests positive for HIV and Hepatitis B C or D as a result of the same Covered Accident, only one benefit amount, the largest, will b e paid.]

[The Company will not pay for any expenses incurred for testing.]

Definitions

For purposes of this benefit:

Occupational Duties means the performance of duties that are:

1. normally performed on behalf of **[**the Policyholder, Subscriber**]**; and
2. assisting, caring for or otherwise involved with, sick or injured persons.

Assigned Duties means performance of duties, whether for pay or on a volunteer basis, that are:

1. assigned by **[**the Policyholder, Subscriber**]**; and
2. assisting, caring for or otherwise involved with, sick or injured persons.

HIV means Human Immunodeficiency Virus, a virus that infects lymphocytes and other cells bearing the CD4 marker, the initial infection of which is known as acute retro viral syndrome.

Blood Test means a positive (reactive) Enzyme-linked Immunosorbent Assay (ELISA) test, confirmed by the Western Blot Test, or other tests that may be approved by the Centers for Disease Control and Prevention and accepted by the Company.

Exclusions

Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[HEPATITIS BENEFIT OCCUPATIONAL *or* ASSIGNED DUTIES OR VOLUNTEER DUTIES ACCIDENT BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss. Such Covered Loss must occur during the performance of Occupational or Assigned Duties and result in the Insured Person acquiring and testing positive for Hepatitis B, Hepatitis C, Hepatitis D within 90 days of the date of an Occupational or -Assigned Duties Covered Accident. The benefit is payable if, within 96 hours of the Covered Accident, the Insured Person: 1) reports the Covered Accident to the Company and the Policyholder in writing; and 2) undergoes a Food and Drug Administration (FDA) approved preliminary screening test for Hepatitis which indicates negativity with respect to the presence of any antibodies or antigens to such disease. The Company must receive written notification of the test results, from the laboratory that performed the test, as soon as reasonably possible.

[If the Insured Person tests positive for HIV and Hepatitis B, C or D as a result of the same Covered Accident, only one benefit amount, the largest, will be paid.]

The Company will not pay for any expenses incurred for testing.

Definitions For purposes of this coverage:

Occupational Duties means the performance of duties that are:
1. normally performed on behalf of **[**the Policyholder, Subscriber**]**; and
2. assisting, caring for or otherwise involved with, sick or injured persons.

Assigned Duties means performance of duties, whether for pay or on a volunteer basis, that are:
1. assigned by **[**the Policyholder, Subscriber**]**; and
2. assisting, caring for or otherwise involved with, sick or injured persons.

Hepatitis means viral hepatitis B, C, and D and does not include Hepatitis A or Hepatitis E.

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[HOME ALTERATION AND VEHICLE MODIFICATION][WHEELCHAIR CONFINEMENT] BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss and is confined to a Wheelchair when all of the following conditions are met:
1. before the date of the Covered Accident, the Insured Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. as a direct result of such Covered Accident, the Insured Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle; and
3. the Insured Person requires home alteration or vehicle modification within one year of the date of the Covered Accident.

Exclusions Exclusions that apply to this benefit are in the *Common Exclusions* Section.**]**

[MEDICAL EVACUATION BENEFIT

The Company will pay the Benefit Amount, shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person**[**or Traveling Companion**]** suffers a Covered Loss **[**or an Emergency Sickness**]** that warrants His Emergency Evacuation while He is outside a 100 mile radius from His current place of primary residence. The Company will pay for Covered Emergency Evacuation Expenses reasonably incurred for all Emergency Evacuations due to all Covered Losses from the same Accident or **[**all Emergency Sicknesses**]** from the same or related causes**]**.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured Person's **[**or Traveling Companion's**]** Covered Loss **[**or Emergency Sickness**]** warrants His Emergency Evacuation. All transportation arrangements made for the Emergency Evacuation must be by the most direct and economical Conveyance and route possible. All transportation arrangements must be made and approved by **AXIS Global Travel Assistance]**

Definitions For purposes of this coverage:

Covered Emergency Evacuation Expense(s) - means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed; or (4) Usual and Customary Charges.

Emergency Evacuation - means, if warranted by the severity of the Insured Person's **[**or Traveling Companion's**]** Covered Loss **[**or Emergency Sickness**]**: (1) the Insured Person's **[**or Traveling Companion's**]** immediate transportation from the place where He suffers a Covered Loss **[**or Emergency Sickness**]** to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Insured Person's **[**or Traveling Companion's**]** transportation to His current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering a Covered Loss **[** or Emergency Sickness **]**and being treated at a local Hospital or other medical facility; or (3) both (1) and (2) above. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such transportation.

[Emergency Sickness - means an illness or disease diagnosed by a Physician which:

1. causes a severe or acute symptom that, if not provided with immediate treatment, would reasonably be expected to result in serious deterioration of the Insured Person's health or place His life in jeopardy; and
2. first manifests itself suddenly and unexpectedly while the Insured Person is covered under this policy.]

Exclusions Exclusions that apply to this coverage are in the Common Exclusions Section.**]**

[REPATRIATION BENEFITS

The Company will pay the Benefit Amount, shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person **[**or Traveling Companion**]** suffers Loss of Life due to a Covered Loss **[**or Emergency Sickness**]** while outside a 100 mile radius from His current place of primary residence, the Company will pay for Covered Expenses reasonably incurred to return His body to His current place of primary residence.

Covered Expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical Conveyance and route possible. or (4)Usual and Customary Charges.

AXIS Global Travel Assistance must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact AXIS Global Travel Assistance **[**in advance.**][**

Exclusions Exclusions that apply to this coverage are in the Common Exclusions Section.**]**

[PARALYSIS BENEFIT

The Company will pay the benefits shown on the *Schedule of Benefits* for that type of Paralysis, subject to all conditions and exclusions, if an Insured Person

suffers a Covered Loss. If the Insured Person suffers more than one type of Paralysis as a result of the same Accident, only one amount, the largest, will be paid.**]**

Exclusions Exclusions that apply to this coverage are in the Common Exclusions Section.**]**

[PERMANENT TOTAL DISABILITY BENEFIT
[Not Applicable to the Insured Person **[70-85] or Older on the date of the Covered Loss]**

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, to the Insured Person whose Total Disability results from a Covered Accident, and within the time period shown in the *Schedule of Benefits*. To qualify for benefits, the Insured Person must remain Totally Disabled during the Benefit Waiting Period shown in the *Schedule of Benefits,* and at the end of the Benefit Waiting Period, must be expected to remain so disabled, as certified by a Physician, for the rest of His life.**]**

[The Insured Person who is currently employed may be insured for Permanent Total Disability Benefits effective on the date other coverages and benefits provided by this Policy become effective for Him. He must be either:

1. **[**performing His regular duties on a **[**full time**]** basis during one of His Employer's scheduled work days, either at one of His Employer's usual places of business or at some other location to which His Employer's business requires Him to travel; or
2. **[**on a scheduled holiday, vacation day or period of Employer-approved paid leave of absence other than sick leave, only if He was performing His regular duties, as described in 1. above, on the preceding scheduled workday.**]]**

[The Insured Person who is not currently employed may be insured for Permanent Total Disability Benefits effective on the date other coverages and benefits provided by this Policy become effective for Him. He must not be:

1. An Inpatient in a Hospital or receiving Outpatient care for chemotherapy or radiation therapy; nor
2. Confined at home under the care of a Physician for sickness or injury; nor
3. Totally Disabled.**]**

The Company will pay Permanent Total Disability Benefits, as shown in the *Schedule of Benefits,* to the Insured Person if His Total Disability results, within the time period shown in the *Schedule of Benefits* of, a Covered Accident. To qualify for benefits, the Insured Person must remain Totally Permanently Disabled during the Benefit Waiting Period shown in the *Schedule of Benefits* and at the end of the Benefit Waiting Period, must be expected to remain so disabled, as certified by a Physician, for the rest of His life.**]**

(Option 1- single lump sum)
[The Company will pay a single lump sum benefit equal to the Lump Sum Benefit shown in the *Schedule of Benefits* **[**less any **[**Accidental Dismemberment**]** benefit paid for the **[**Covered Loss**]** causing the Total Disability**].]**

(Option 2- monthly benefits)
[The Company will pay monthly benefits as shown in the *Schedule of Benefits* beginning at the end of the Benefit Waiting Period. Monthly benefit payments will be paid until the earliest of the following occurs:

1. The Insured Person fails to provide certification by a Physician that He is expected to remain Totally Disabled for the rest of His life;
2. The Insured Person dies; or
3. The total of all Monthly Benefits equals **[**the Principal Sum less any Accidental Dismemberment benefits paid for Covered Losses sustained in

the same Covered Accident**]** *or* **[**the total of monthly benefits specified in the *Schedule of Benefits*.**]]**

Optional:
If the Insured Person dies before receiving the total of benefits specified in 3. above, a single payment equal to the present value of the remaining payments that would have been paid will be made to His beneficiary.

(*Option 3 - combination of Lump Sum and Monthly Benefits is elected)*
[The Company will pay a single lump sum equal to the amount shown in the *Schedule of Benefits* or, if less, the Principal Sum reduced by any **[**Accidental Dismemberment**]** benefits paid for the same Covered Accident.**]**
[The Company will pay monthly benefits as shown in the *Schedule of Benefits* as long as the total of any **[**Accidental Dismemberment**]** benefits, the lump sum benefit and monthly benefits does not exceed the Principal Sum. Monthly benefits will be paid until the earliest of the following occurs:

1. The Insured Person fails to provide certification by a Physician that He is expected to remain Totally Disabled for the rest of His life;
2. The Insured Person dies; or
3. The total of all Monthly Benefit Payments, the Lump Sum Benefit and any **[**Accidental Dismemberment**]** benefit paid for the same Covered Accident equals the Principal Sum.**]**

Optional:
If the Insured Person dies before receiving the total of benefits specified in 3. above, a single payment equal to the present value of the remaining payments that would have been paid will be made to His beneficiary.

(*Option* 4 - *monthly benefits with limited benefit period if disability begins on/after age* 62)
[The Company will pay monthly benefits as shown in the *Schedule of Benefits* beginning at the end of the Benefit Waiting Period. Monthly benefit payments will be paid until the earliest of the following occurs:

1. the Insured Person fails to provide certification by a Physician that He is expected to remain Totally Disabled for the rest of His life; or
2. the Insured Person dies; or
3. the end of the benefit period shown in the *Schedule of Benefits*; or
4. the total of all Monthly Benefits equals the Principal Sum less any Accidental Dismemberment benefits paid for Covered Losses sustained in the same Covered Accident.**]** [the total of monthly benefits specified in the Schedule of Benefits].

Optional:
If the Insured Person dies before receiving the total of benefits specified in 3. above, a single payment equal to the present value of the remaining payments that would have been paid will be made to His beneficiary.

Exclusions

Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[REHABILITATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, when the Insured Person requires Rehabilitation after sustaining a Covered Loss. The Insured Person must require Rehabilitation within 365 days after the date of the Covered Accident.

Definitions

For purposes of this benefit:

Rehabilitation means medical services, supplies, or treatment, Hospital Confinement or part of a Hospital Confinement that satisfies all of the following conditions:

1. are essential for physical Rehabilitation required due to the Insured Person's Covered Loss or Injury;
2. meet generally accepted standards of medical practice;
3. are performed under the care, supervision or order of a Physician; and;
4. prepare the Insured Person to return to His or any other occupation.

Exclusions

Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[RELOCATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss that occurs during Relocation.

This benefit is in effect beginning when the Insured Person departs from His prior place of residence, or if later, His prior place of employment and begins travel to His new place of residence or employment. It ceases to be in effect when the Insured Person begins His first full day of employment at His new location or, if later, when He arrives at His new place of residence**[**2 -10 days**]** from the date this coverage began.**]**

[Coverage for this benefit will be in effect during the Insured Person's Personal Deviation only if indicated in the *Schedule of Benefits*.]

Definitions

For purposes of this benefit:

Relocation means a change in the Insured Person's assigned place of employment for **[**the Policyholder, Subscriber,**]** which necessitates a change of residence, and for which **[**the Policyholder, Subscriber,**]** pays travel expenses.

Exclusions

Exclusions that apply to this benefit are in the Common Exclusions Section.

[SEATBELT [AND AIRBAG] [SAFETY DEVICE] BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, when the Insured Person's death results from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in a Private Passenger Automobile. **[**An additional benefit is provided if the Insured Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).**]**

Verification of proper use of the seatbelt at the time of the Accident **[**and that the Supplemental Restraint System properly inflated upon impact**]** must be a part of an official police report of the Accident or be certified, in writing, by the investigating officer(s) and submitted with the Insured Person's claim to the Company .

If such certification or police report is not available or it is unclear whether the Insured Person was wearing a seatbelt **[**or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System,] **[**the

Company will pay a default benefit shown in the *Schedule of Benefits* to the Insured Person's beneficiary.**]**

[In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.**]**

[Definitions For purposes of this benefit:

[Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas or a child safety device.**]**

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[SPECIAL EDUCATION BENEFIT

The Company will pay the Benefit Amount, up to the Maximum Benefit shown in the *Schedule of Benefits,* for each qualifying Dependent Child **[**and surviving Spouse**]** of the Insured Person whose death **[**or Permanent Total Disability**]** for which an Accidental Death Benefit **[**or Permanent Total Disability Benefits**] [**is, are**]** payable under this Policy. This benefit is subject to the conditions and exclusions described below.

[A qualifying Dependent Child must:
1. be a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the Insured Person's Covered Loss**]**; and
2. continue His education as a full-time student in such accredited school of higher learning; and
3. incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.**]**

[A qualifying Dependent Child must:
1. begin studies as a full-time student at a school of higher learning before reaching the limiting Age shown in the Dependent Child definition below; and
2. continue His education as a full-time student; and
3. incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.**]**

Option III:
[A qualifying surviving Dependent Child must:
1. begin studies as a full-time student at a school of higher learning before reaching the limiting age shown in the Dependent Child definition below; and
2. continue His education as a full-time student; and
3. incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

A qualifying surviving Spouse must:
1. begin studies in any accredited school for the purpose of retraining or refreshing skills needed for employment within **[**one year**]** of the date of **[**the Insured Person's**]** Covered Loss; 2. continue studies in such accredited school; and
3. incur expenses payable directly to, or approved by, such school.**]**

Payments will be made to each qualifying Dependent Child or to the child's legal guardian, if the child is a minor at the end of each year for the number of years shown in the *Schedule of Benefits*. The Company must receive proof satisfactory to the Company of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the Insured Person died **[**or completed the Benefit Waiting Period for Permanent Total Disability benefits**]**, if the surviving Dependent Child was a full-time student on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date He begins studies in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

If no Dependent Child qualifies for Special Education Benefits within 730 days of the Insured Person's death **[**or completion of the Benefit Waiting Period for Permanent Total Disability Benefits**]**, the Company will pay the default benefit shown in the *Schedule of Benefits* to **[**Him if He is Permanently Totally Disabled, or**]** His beneficiary.

[Payments will be made to the surviving Spouse at the end of each year for the number of years shown in the *Schedule of Benefits.* The Company must receive proof satisfactory to the Company of the Spouse's attendance within 31 days of the end of each year. The first year for which a Special Education Benefit is payable will begin on the date the surviving Spouse begins studies in an accredited school for the first time following the date the Insured Person died **[**or completed the Benefit Waiting Period for Permanent Total Disability benefits**]**. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.**]**

[If a surviving Spouse does not qualify for Special Education Benefits within 730 days of the Insured Person's death or completion of the Benefit Waiting Period for Permanent Total Disability Benefits, the Company will pay the default benefit shown in the *Schedule of Benefits* to **[**the Insured Person if He is Permanently Totally Disabled, or**]** His beneficiary.**]**

Exclusions

Exclusions that apply to this benefit are in the *Common Exclusions* Section.**]**

[TOTAL DISABILITY [WEEKLY *or* **MONTHLY] INCOME BENEFIT**

The Company will pay **[**weekly *or* monthly**]** Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, to the Insured Person whose Total Disability results from, and within the number of days specified in the *Schedule of Benefits* of, a Covered Accident [or Emergency Sickness]. Disability benefits will begin when a Totally Disabled Insured Person satisfies the Benefit Waiting Period shown in the *Schedule of Benefits* and will end on the earliest of the date He :

1. dies;
2. is no longer Totally Disabled;
3. fails to provide certification by a Physician that He remains Totally Disabled;
[4. is eligible to receive **[**Accidental Death and Dismemberment benefits**]** **[**Permanent Total Disability benefits**]** for the same Covered Accident [or Emergency Sickness]**]**;
5. reaches the end of the Maximum Benefit Period shown in the *Schedule of Benefits.*

[Weekly *or* Monthly**]** Total Disability Benefits are based on **[**a 7-day week *or* a 30-day month**]**. Any Disability Benefit payable for less than a full **[**week, month**]** will be pro-rated.

Once the Insured Person is eligible to receive Disability Income Benefits, separate periods of Total Disability will be considered one continuous period of Disability if:

1. they result from the same Covered Accident [or Emergency Sickness]; and
2. they are separated by no more than 14 consecutive days.

Exclusions Exclusions that apply to this benefit are in the Common Exclusions Section.**]**

[Critical Illness Rider]

[HEALTH SCREENING BENEFIT

The Company will pay the Per Test Amount under Health Screening Benefit shown in the Rider Schedule when an **[**Insured Person**]** undergoes routine testing **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**,. Services covered are: blood test for triglycerides; breast ultrasound; chest x-ray; colonoscopy; electrocardiogram; fasting blood glucose test; flexible sigmoidoscopy; hem cult stool analysis; mammography; Pap test; PSA (blood test for prostate cancer); serum cholesterol test to determine level of HDL and LDL; serum protein electrophoresis (blood test for myeloma); bone marrow; CA 125 blood test; CA 15-3 blood test for breast cancer; CEA blood test for colon cancer and cervical cancer screening, **[**breast biopsy,**] [**or**] [**any cancer biopsy,**]** dental cancer screening, stress test (bicycle or treadmill). Service must be ordered or prescribed by a Physician, received while the **[**Insured Person**]**'s coverage under the Policy is in force **[**and a charge must be incurred**]**. No benefit is payable for any tests in excess of the Test Frequency Maximum shown in the Rider Schedule.**]**

CRITICAL ILLNESS DIAGNOSIS BENEFITS

If, while coverage under the Policy is in force, an **[**Insured Person**]** is Diagnosed with a Critical Illness by a Physician, the Company will pay the Benefit Amount shown in the Rider Schedule, subject to the Diagnostic Requirements, **[**Reduction Schedule**]** and Benefit Payment Conditions listed below.

[Once a Critical Illness has been Diagnosed and a First Diagnosis Benefit has become payable to an **[**Insured Person**]** for that Critical Illness, no benefits are payable for that Insured Person with respect to the Diagnosis of any other Critical Illness.**] 1**

[Once a Critical Illness has been Diagnosed and a First Diagnosis Benefit has become payable to an **[**Insured Person**]** for that Critical Illness, a First Diagnosis Benefit for a separate and subsequently Diagnosed Critical Illness will not be payable unless that subsequently Diagnosed Critical Illness is medically unrelated to the previously Diagnosed Critical Illness.**]2**

[Once a Critical Illness has been Diagnosed and a First Diagnosis Benefit has become payable to an **[**Insured Person**]** for that Critical Illness, a Recurrence Benefit may become payable for a recurrence of that same Critical Illness but no benefits are payable for that **[**Insured Person**]** with respect to the Diagnosis of any other Critical Illness.**] 3**

[Once a Critical Illness has been Diagnosed and a First Diagnosis Benefit has become payable to an **[**Insured Person**]** for that Critical Illness, a Recurrence Benefit may become payable for a recurrence of that same Critical Illness, but a First Diagnosis Benefit for a separate and subsequently Diagnosed Critical Illness will not be payable unless that subsequently Diagnosed Critical Illness is medically unrelated to the previously Diagnosed Critical Illness.**] 4**

Benefit Payment Conditions

Payment of benefits upon the first Diagnosis of the Critical Illnesses listed below are subject to the following:

1. **[**the Diagnosis is made within the United States, it territories or possessions;**]**
2. the Diagnosis is made while the **[**Insured Person's**]** coverage is in force under the Policy;
3. payment is not precluded by any general or specific exclusion or limitation set forth in this Rider or any failure to meet any condition precedent set out below;**[**
4. the **[**Insured Person**]** survives for at least 30 days after the date the Critical Illness is Diagnosed.**]**

Diagnostic requirements

- **All Critical Illnesses** – The Company reserves the right to have any Critical Illness Diagnosis reviewed by a Physician of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, the Company shall have the right to request an examination of either the **[**Insured Person**]** or the evidence used in arriving at such Diagnosis by an independently acknowledged expert selected by the Company in the applicable field of medicine.

  The opinion of such expert as to such Diagnosis shall be binding on both the **[**Insured Person**]** and the Company.

[Advanced Alzheimer Disease

First Diagnosis If an **[**Insured Person**]** is first Diagnosed with Advanced Alzheimer Disease **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Advanced Alzheimer Disease shown in the Rider Schedule.

Definitions For purposes of this benefit:

Advanced Alzheimer's Disease means a degenerative disorder of brain nerve cells manifested by memory loss, confusion and disorientation; usually begins in middle or late life with gradual progression.

Diagnostic requirements
The **[**Insured Person**]** must exhibit loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing. It must result in significant reduction in mental and social functioning such that the **[**Insured Person**]** requires substantial assistance in performing at least **[**1-6**]** of the Activities of Daily Living. The Diagnosis of Advanced Alzheimer's Disease must be made by a legally qualified, board certified neurologist. **]**

[Aortic Surgery

First Diagnosis If an **[**Insured Person**]** is first Diagnosed and receives Aortic Surgery **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Aortic Surgery shown in the Rider Schedule.

Definitions For purposes of this benefit:

Aortic Surgery means undergoing surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches. The definition does not include surgical procedure (for example the insertion of stents) or endovascular repair and surgery following traumatic injury to the aorta.**]**

[Activities of Daily Living (ADL) Deficit [Loss of Independent Living]

First Diagnosis If an **[**Insured Person**]** is first Diagnosed as having an ADL Deficit **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for ADL Deficit shown in the Rider Schedule of Benefits.

Diagnostic requirements
The Diagnosis must indicate that the condition is expected to be permanent. The **[**Insured Person**]** must continue to be under the regular and appropriate care of a Physician.**]**

[Benign Brain Tumor

First Diagnosis If an **[**Insured Person**]** is first Diagnosed as having an Benign Brain Tumor **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Benign Brain Tumor shown in the Rider Schedule.

[The Benign Brain Tumor benefit is paid in lieu of the ADL Deficit benefit.**]**

Definitions For purposes of this benefit:

Benign Brain Tumor means a non cancerous tumor in the brain that either requires surgical excision or causes permanent neurological impairment persisting for at least **[**3-12**]** consecutive months.

Benign Brain Tumor does not include:

1. Cysts, granulomas, malformation in, or of, the arteries or veins of the brain; or
2. Hematomas and /or tumors of the pituitary gland or spine.

Diagnostic requirements
The Diagnosis shall be based on objective clinical findings and laboratory data that confirm the presence of a non cancerous tumor of the brain and demonstrate evidence of permanent neurological impairment. The permanent neurological impairment must result in the **[**Insured Person's**]** inability to perform without assistance at least **[**2-6**]** of the Activities of Daily Living. The Diagnosis must be confirmed by a Physician who is a neurologist.**]**

[Coma

First Diagnosis If an **[**Insured Person**]** is first Diagnosed as being Comatose **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Coma shown in the Rider Schedule.

Definitions For purposes of this benefit:

Coma or Comatose means a profound state of unconsciousness from which the **[**Insured Person**]** is not likely to be aroused through powerful stimulation. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment, illness or injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of illness or injuries.

Diagnostic requirements
The Coma must continue for **[**30-180 consecutive days**]** and must be Diagnosed and treated regularly by a Physician. **]**

[Coronary Artery Bypass

First Diagnosis If an **[**Insured Person**]** is first Diagnosed with a condition that necessitates a Coronary Artery Bypass and receives the Coronary Artery Bypass **[**more than **[**0-90**]** days**]** after the Effective Date **[** of this Rider**]**, the Company will pay the Benefit Amount for Coronary Artery Bypass shown in the Rider Schedule.

[Recurrence If a First Diagnosis Benefit for Coronary Artery Bypass has been paid and more than **[**3–24**]** months following the first Diagnosis, such Insured Person is Diagnosed with a subsequent condition that necessitates a Coronary Artery Bypass and receives the Coronary Artery Bypass, the Company will pay the Recurrence Benefit Amount for Coronary Artery Bypass shown in the Rider Schedule**.]**

Definitions For purposes of this benefit:

Coronary Artery Bypass – means the use of non-coronary blood vessel or blood vessels (either artery or vein) to surgically bypass obstructions in a native coronary artery or arteries.

Diagnostic requirements
The Diagnosis of the condition that necessitates the need for a Coronary Artery Bypass must be made by a cardiologist and based on angiographic evidence of the underlying disease.**]**

[Heart Attack

First Diagnosis If an **[**Insured Person**]** is Diagnosed as having suffered a Heart Attack **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount shown for Heart Attack in the Rider Schedule.
[Recurrence If a First Diagnosis Benefit for Heart Attack has been paid and more than **[**3–24**]** months following the first Diagnosis, such Insured Person is Diagnosed as having had a subsequent Heart Attack, the Company will pay the Recurrence Benefit Amount for Heart Attack shown in the Rider Schedule**.]**

Definitions For purposes of this benefit:

Heart Attack means the death of a portion of the heart muscle as a result of inadequate cardiac blood supply to the relevant area.

Diagnostic requirements
The Diagnosis of Heart Attack must be based on an event which contains all of the following criteria: (1) associated new electrocardiographic (EKG) changes which support the Diagnosis; (2) concurrent diagnostic elevation of cardiac enzymes above normal levels; and (3) confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.**]**

[Heart Valve Replacement

First Diagnosis. If an **[**Insured Person**]** is Diagnosed with a condition that necessitates a Heart Valve Replacement and receives the Heart Valve Replacement **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount shown for Heart Valve Replacement in the Rider Schedule.

Definitions For purposes of this benefit:

Heart Valve replacement means surgery requiring median sternotomy (surgery through the breastbone) on the advice of a Cardiologist to repair one or more heart valves.**]**

[Invasive Cancer

First Diagnosis If an **[**Insured Person**]** is first Diagnosed with Invasive Cancer **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Invasive Cancer shown in the Rider Schedule.
[Recurrence If a First Diagnosis Benefit for Invasive Cancer has been paid and more than **[**3–24**]** months following the first Diagnosis, such Insured Person is Diagnosed as having had a subsequent occurrence of Invasive Cancer, the Company will pay the Recurrence Benefit Amount for Invasive Cancer shown in the Rider Schedule**.]**

Definitions For purposes of this benefit:

Invasive Cancer – means a disease which is manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. For the purposes of this definition, it does NOT mean the following:

1. pre-malignant lesions, benign tumors or polyps;
2. leukoplakia;
3. hyperplasia;
4. carcinoid;
5. any tumors in the presence of any human immuno-deficiency virus (HIV);
6. polycythemia;
7. stage 1 Hodgkin's disease;
8. stage A prostate cancer;
9. Duke's stage A colon cancer;
10. intraductal non-invasive breast cancer;
11. stage 0 or 1 transitional cell carcinoma of urinary bladder; and
12. any skin cancer other than malignant melanoma with a depth of 1mm or deeper or greater than Clark level 2.
13. $T_1N_0M_0$ (TNM Classification System) papillary carcinoma of the thyroid less than 1 cm in diameter;
14. chronic Lymphocytic Leukemia RAI stage 0;
15. In-Situ Cancer.

In-Situ Cancer – means carcinoma cancer that is confined to the organ where it first developed and has not spread to other parts of the body. In-Situ Cancer includes Stage 1 Hodgkin's disease.

Diagnostic requirements
Invasive Cancer must be positively Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology, upon the basis of a microscopic examination of fixed tissues, or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard.**]**

[In-Situ Cancer

First Diagnosis If an **[**Insured Person**]** is first Diagnosed with In-Situ Cancer **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for In-Situ Cancer shown in the Rider Schedule.

[Recurrence If a First Diagnosis Benefit for In-Situ Cancer has been paid and more than **[**3–24**]** months following the first Diagnosis, such Insured Person is Diagnosed as having had a subsequent occurrence of In-Situ Cancer, the Company will pay the Recurrence Benefit Amount for In-Situ Cancer shown in the Schedule of Benefits**.]**

Definitions For purposes of this benefit:

In-Situ Cancer – means carcinoma cancer that is confined to the organ where it first developed and has not spread to other parts of the body. In-Situ Cancer includes Stage 1 Hodgkin's disease.

Diagnostic requirements
In-Situ Cancer must be positively Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology, upon the basis of a microscopic examination of fixed tissues, or preparations from the hemic

system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard.**]**

[Kidney (Renal) Failure

First Diagnosis If an **[**Insured Person**]** is first Diagnosed with Kidney (Renal) Failure **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Kidney (Renal) Failure shown in the Rider Schedule.
[Recurrence If a First Diagnosis Benefit for Kidney (Renal) Failure has been paid and more than **[**3–24**]** months following the first Diagnosis, such Insured Person is Diagnosed as having had subsequent Kidney (Renal) Failure, the Company will pay the Recurrence Benefit Amount for Kidney (Renal) Failure shown in the Schedule of Benefits**.]**

Definitions For purposes of this benefit:

> **Kidney (Renal) Failure** means end stage failure which: (1) presents as a chronic irreversible failure of at least one of the kidneys to function; and (2) necessitates treatment by regular renal dialysis or kidney transplant.

Diagnostic requirements
The Diagnosis of Kidney (Renal) Failure must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.**]**

[Loss of Sight, Speech or Hearing

First Diagnosis If an **[**Insured Person**]** is first Diagnosed as having suffered Loss of Sight, Speech or Hearing **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Loss of Sight, Speech or Hearing shown in the Rider Schedule.

Definitions For purposes of this benefit:

> **Loss of Sight, Speech, or Hearing** means the irreversible loss of sight in both eyes, the irreversible loss of the ability to speak, or the irreversible loss of hearing for all sounds in both ears.

Diagnostic requirements
The Diagnosis of Loss of Sight, Speech, or Hearing must be made by a licensed professional or specialist in the applicable field of medicine. The Diagnosis of Loss of Sight must indicate that corrective visual acuity is greater than 20/200 in both eyes or the field of vision is less than 200 degrees in both eyes. The Diagnosis of Loss of Speech must include documented evidence of the illness for the continuous 12-month period prior to the Diagnosis. The Diagnosis of Loss of Hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels while utilizing a hearing aid.**]**

[Multiple Sclerosis

First Diagnosis If an **[**Insured Person**]** is first Diagnosed with Multiple Sclerosis **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Multiple Sclerosis shown in the Rider Schedule.

Diagnostic requirements
The Diagnosis of Multiple Sclerosis must be determined by a consultant neurologist. There must be a current clinical impairment of motor or sensory function, which has persisted for a continuous period of at least **[**6, 12 18**]** months. **]**

[Organ Transplant

First Diagnosis If an **[**Insured Person**]** is first Diagnosed as needing an Organ Transplant and such Insured Person undergoes the Organ Transplant **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**; the Company will pay the Benefit Amount for Organ Transplant shown in the Rider Schedule.

Definitions For purposes of this benefit:

Organ Transplant means having undergone surgery as a recipient of a transplant as follows:

1. human bone marrow using hematopoietic stem cells preceded by total bone marrow ablation; or
2. whole human organs limited to: heart, lung, liver, or pancreas because of the irreversible end stage failure of such organ.

For the purpose of this definition, Organ Transplant does **NOT** mean*:*

1. other stem cell transplant; or
2. part of an organ transplant .

Diagnostic requirements
The Diagnosis and medical necessity for an Organ Transplant must be determined as follows:

- For a heart transplant: by a Physician who is a transplant cardiologist and supported by objective clinical findings and laboratory data.
- For a liver transplant: by a Physician who is a gastroenterologist and supported by objective clinical findings and laboratory data. The need for a liver transplant resulting either directly or indirectly from drug overdose or excessive alcohol ingestion is not covered under this Benefit
- For a lung transplant: by a Physician who is a pulmonologist and supported by objective clinical findings and laboratory data including
    - Pulmonary function test;
    - Chest X-Ray; and
    - Evidence of end stage lung disease
- For pancreas transplant: by a Physician who is an endocrinologist or gastroenterologist and supported by objective clinical findings and laboratory data including
    - Diagnosis of Type 1 diabetes; and
    - Evidence of progressive end organ dysfunction.
- For Bone Marrow Transplant: by a Physician who is an oncologist or hematologist and supported by objective clinical findings and laboratory data including pathology reports supporting the underlying Diagnosis.**]**

[Paralysis

First Diagnosis If an **[**Insured Person**]** is first Diagnosed as being Paralyzed **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Paralysis shown in the Rider Schedule.

Definitions For purposes of this benefit:

Paralysis/Paralyzed – means Quadriplegia, Paraplegia, Hemiplegia or Uniplegia that is expected to last for a continuous period of 12 months or more from either the date of the injury causing Paralysis or the date of the diagnosis of the illness causing Paralysis. "Quadriplegia" means the complete and irreversible Paralysis of both

upper and lower limbs. "Paraplegia" means the complete and irreversible Paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible Paralysis of the upper and lower limbs of the same side of the body. "Uniplegia" means the complete and irreversible paralysis of one limb. "Limb" means entire arm or entire leg.

Diagnostic requirements
The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis.**]**

[Specified Disease
First Diagnosis If an **[**Insured Person**]** is first Diagnosed with a Specified disease **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Initial Hospitalization Benefit amount shown in the Rider Schedule, when **[**an **[**Insured Person**]** is confined to a Hospital for at least 12 hours or more as a result of receiving treatment for a Specified Disease. **[**This benefit is payable only once per Period of Confinement**][**and once per calendar year**]]**.

[The Company will pay the Hospital Confinement Benefit Amount shown in the Rider Schedule when an **[**Insured Person**]** is Confined to a Hospital for a Diagnosed Specified Disease.**]**

Definitions For purposes of this benefit:

Specified Disease means one of the following diseases; adrenal hypo function, Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig Disease), botulism, bubonic plague, cerebral palsy, cholera, cystic fibrosis, diphtheria, legionnaires disease, malaria, meningitis, muscular dystrophy, polio, rabies, Reye's syndrome, scarlet fever, scleroderma, sickle cell anemia, systemic lupus, tetanus, toxic shock syndrome, tuberculosis, typhoid fever, variant Creutzfeldt-Jakob disease (mad cow disease). The diagnosis must be made upon a tissue specimen, culture, and/or titer.

[Hospital Confinement or **Confined to a Hospital** means a stay of **[**24-98**] [**or more**]** consecutive hours as a registered resident bed-patient in a Hospital. Separate Hospital Confinements due to the same Specified Disease will be treated as one Hospital Stay unless separated by at least **[**30 days - 180 days**].]**

[Severe Burn

First Diagnosis If an **[**Insured Person**]** is first Diagnosed as having suffered a Severe Burn **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Severe Burn shown in the Rider Schedule.

Definitions For purposes of this benefit:

Severe Burn/Severely Burned means cosmetic disfigurement of at least 20% of the surface of a body area that is a second degree, partial thickness burn or a third-degree, full-thickness burn, as determined by a Physician. (A second degree, partial thickness burn, is the destruction of the skin through the epidermal layers, extending into the dermis layer; a third degree, full-thickness burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).

[Stroke

First Diagnosis If an **[**Insured Person**]** is first Diagnosed with having suffered a Stroke **[**more than **[**0-90**]** days**]** after the Effective Date **[**of this Rider**]**, the Company will pay the Benefit Amount for Stroke shown in the Rider Schedule.

[Recurrence. If a First Diagnosis Benefit for Stroke has been paid and more than **[**3–24**]** months following the first Diagnosis, such Insured Person is Diagnosed as having had a subsequent Stroke, the Company will pay the Recurrence Benefit Amount for Stroke shown in the Rider Schedule**.]**

Definitions For purposes of this benefit:

Stroke – means: (1) a cerebrovascular incident caused by infarction of brain tissue, cerebral hemorrhage, thrombosis, or embolization from an extra-cranial source lasting more than **[**24**]** hours; and (2) producing measurable neurological deficit persisting for at least **[**30**]** days following the occurrence of the Stroke.

The following are not considered Strokes:

1. Transient Ischemic Attacks (TIAs)
2. Vertebro-Basilar Insufficiency
3. Incidental findings on imaging studies

Transient Isechemic Attack (TIA) means a neurological condition or event with the signs and symptoms of a stroke, but which disappear within a short period of time with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.**]**

Diagnostic requirements
The Diagnosis of Stroke must be made by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.**]**

The Description of Benefits listed below are sample wordings. Actual wording may vary based on approved wording from state Insurance Regulators. Please see Proposed Coverage Offering 11I for state/province and group eligibility availability by state.

[Section I: DEATH BENEFITS

[I.A. COVERED INJURY DEATH BENEFIT
If an Insured Person sustains a Covered Injury that directly causes the loss of life, the Company will pay the Principal Sum shown on the *Policy Schedule of Benefits*. **[**The death for the Covered Injury must occur with the time period specified on the *Policy Schedule of Benefits.***]]**

[I.B. COVERED ILLNESS DEATH BENEFIT
If an Insured Person suffers a Covered Illness that directly causes the loss of life, the Company will pay the Principal Sum shown on the *Policy Schedule of Benefits*. **[**The death or medical treatment for the Covered Illness must occur within the time periods specified on the *Policy Schedule of Benefits*. The requirement that the death occurs or that the medical treatment for the Covered Illness be received within the time period shown the *Policy Schedule of Benefits* is waived for Infectious Disease.**]]**

[I.C. [HIV POSITIVE][DIAGNOSIS LUMP SUM] BENEFIT
If an Insured Person tests positive for HIV as a direct result of participation in a Covered Activity, the Company will pay the Benefit Amount shown on the *Policy Schedule of Benefits.*

In order to receive this benefit, the Insured Person must:
1. test negative for HIV antibodies within **[**24-96 hours**]** of such Covered Activity; and
2. test positive for HIV antibodies in a subsequent blood test within **[**one year**]** of the date of the Covered Activity.

An Insured Person may choose, as an option, to receive this benefit in lieu of the **[**Permanent Physical Impairment Benefit**][**and/or**][**Covered Illness Death Benefit**][**or**][**Covered Injury Death Benefit**]**.

If an Insured Person receives this benefit, the **[**Covered Injury Death Benefit**]**, **[**Covered Illness Death Benefit**]**, **[**or Permanent Physical Impairment Benefit**]** will not be applicable for the same Covered Activity.**]**

[I.D. SPONSORING ORGANIZATION] BEREAVEMENT BENEFIT
If a **[**Covered Injury Death Benefit**][**or**][**Covered Illness Death Benefit**]** is payable under this Policy, an amount up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* will be paid for out-of-pocket expenses actually incurred by the **[**Sponsoring Organization**]** for the following expenses that are directly associated with an Insured Person's loss of life: 1) reasonable cost of bereavement counseling and 2) the reasonable costs associated with the memorial service, wake, honor guard, or other tribute to the Insured Person. This benefit is payable to the **[**Sponsoring Organization**].]**

[I.E. FINAL EXPENSES BENEFIT
If a **[**Covered Injury**][**or**][**Covered Illness**]** Death Benefit is payable under this Policy, an amount up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* will be paid for the following out-of-pocket expenses actually incurred by the beneficiary for expenses directly associated with an Insured Person's loss of life: all expenses related to the funeral and burial of the Insured Person, including transfer of the remains to the funeral home, all services of the Funeral Director and staff, embalming, dressing cosmetology and hair, use of the funeral home, printing and design cost use of the hearse and any limousines , cost of the casket, burial vault, cemetery charges including the grave, opening grave site, head stone and other items such as tents for protection from the weather, cremation expenses including transfer of the remains to the crematorium, and travel and other expenses of the Immediate Family, and all other expenses reasonably related to funeral services for an Insured Person of the **[**Sponsoring Organization.**]**
This benefit will be payable, at our option in good faith, to the individual who paid for the covered expenses or who is financially responsible for paying such expenses.

[Any such payments made in good faith will fully discharge us to the extent of such payment.**]]**

[I.F. DEPENDENT CHILD BENEFIT

If a **[**Covered Injury**][**or**][**Covered Illness**]** Death Benefit is payable under the Policy, the Company shall pay the Benefit Amount shown on the *Policy Schedule of Benefits* for each Dependent Child. The Dependent Child Benefit is payable in addition to the **[**Covered Injury Death Benefit**][**or**][**Covered Illness Death Benefit**]** and other losses payable under this Policy.

The Benefit Amount will be paid directly to the Insured Person's beneficiary.

Payment made in this manner will release the Company from all liability to the extent of any payment made.**]**

[I.G. SPOUSAL BENEFIT
If a **[**Covered Injury Death Benefit**][**or**][**Covered Illness Death Benefit**]** is payable under the Policy, the Company shall pay the Benefit Amount shown on the *Policy Schedule of Benefits* to the Spouse of the deceased Insured Person.**]**

[I.H. SEATBELT [AND AIRBAG] BENEFIT
If a Covered Injury Death Benefit is payable under this Policy and the Insured Person's death occurred in an Accident while he or she was wearing a properly fastened **[**automobile**]** seatbelt, the Company will pay the Seatbelt Benefit Amount shown on the *Policy Schedule of Benefits*.**[**If the Seat Benefit is payable, the additional Airbag Benefit Amount shown on the *Policy Schedule of Benefits* will be paid if the Insured Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag) when the Accident occurred.**]**

[This Seatbelt Benefit is not payable for Covered Injury sustained by an Insured Person while standing inside or on the tailboard of any vehicle.**]]**[9]

[Section II: IMPAIRMENT BENEFITS

[II.A. DISMEMBERMENT, LOSS OF SPEECH OR HEARING BENEFIT
If an Insured Person sustains a Covered Injury that directly causes any of the Losses shown in the Table of Losses below, the Company will pay the Benefit Amount shown for the Loss**[**If more than one Loss results from the same Accident, the maximum amount payable is the Principal Sum.**]** Unless provided otherwise in this Policy, these benefits will be paid in addition to any other payment for a **[**Covered Injury**][**or**][**Covered Illness**]** to which an Insured Person may be entitled under this Policy.

Loss of hand or foot means complete severance through or above the wrist or ankle. Loss of arm or leg means complete severance through or above the elbow or knee joint. Loss of thumb or index finger means actual severance through or above the metacarpi-phalange joints. Loss of second, third or fourth finger of either hand means actual severance of two or more phalanges. However, if one complete phalange but less than two phalanges is severed, the Company will pay **[**50%-100%**]** of the percentage shown for this loss shown in the Table of Losses below. Loss of speech means the entire and irrecoverable loss of the entire ability to speak. **[**Complete loss of hearing means the entire and irrecoverable loss of the entire ability to hear in both ears.**][**Complete loss of hearing in one ear means the entire and irrecoverable loss of the entire ability to hear in one ear.**]**

[When medical expenses are incurred in an effort to prevent one of these Losses, the amount payable for such Loss may be used for such medical expenses if the Maximum Medical Expense Benefit Amount shown on the *Policy Schedule of Benefits* has been paid. Any benefits paid for medical expenses in excess of the Maximum Medical Expense Benefit Amount will be deducted from the benefits payable under this benefit if the medical treatment fails to prevent the specific Loss.**]**

Table of Losses

Loss	**Benefit Amount**
Loss of Both Hands or Both Feet	100% of the Impairment Principal Sum
Loss of One Hand and One Foot	100% of the Impairment Principal Sum
Complete Loss of Speech	100% of the Impairment Principal Sum
[Complete Loss of Hearing in One Ear	100% of the Impairment Principal Sum**]**
Complete Loss of Hearing in Both Ears	100% of the Impairment Principal Sum
Loss of One Arm or One Leg	75% of the Impairment Principal Sum
Loss of One Hand	50% of the Impairment Principal Sum
Loss of One Foot	50% of the Impairment Principal Sum
Loss of Thumb or Index Finger of Either Hand	25% of the Impairment Principal Sum
[Loss of Thumb or Index Finger of both Hands	25% of the Impairment Principal Sum**]**
Loss of Second, Third or Fourth Finger of Either Hand	12.5% of the Impairment Principal Sum
Loss of any Joint on Either Finger or Toe	6.25% of the Impairment Principal Sum

]

[II.B. VISION IMPAIRMENT BENEFIT
If an Insured Person suffers a vision impairment due to a **[**Covered Injury**][**or**][**Covered Illness**]**, the Company will pay a Vision Impairment Benefit for each impaired eye. The amount of the Vision Impairment Benefit for each eye shall be the product of the Percentage of Vision Impairment Principal Sum corresponding to the Degree of Vision Impairment as shown below, multiplied by the Vision Impairment Principal Sum shown in the *Policy Schedule of* Benefits.

If an Insured Person's sight was less than 20/20 before the **[**Covered Injury**][**or**][**Covered Illness**]** the Company will measure the vision impairment based upon the additional impairment measured after the **[**Covered Injury**][**or**][**Covered Illness**]**. Loss of Sight means the permanent, irrecoverable loss of the entire sight in that eye.

Vision Impairment Chart

Degree of Vision Impairment	**Percentage of Vision Impairment Principal Sum Payable for Each Eye**
20/20	0.00%
20/30	2.75%

20/40	5.50%
20/50	8.25%
20/60	11.00%
20/80	16.50%
20/100	22.00%
20/120	28.00%
20/150	36.00%
20/180	45.50%
20/200 or worse	50.00%
Loss of Sight of Both Eyes (20/200 or worse in both eyes)	100%
Loss of Sight of One Eye (20/200 or worse)	50.00%

]

[II.C. COSMETIC DISFIGUREMENT FROM BURNS BENEFIT

If an Insured Person suffers Cosmetic Disfigurement From Burns as a result of a Covered Injury, the Company will pay a benefit payable based on the following formula:

1. determination of the Area Classification Factor for the burned area as set forth in the Cosmetic Burns Schedule as shown below;
2. the Area Classification Factor is multiplied by the percentage of body surface actually burned, up to the Maximum Allowable Percentage for Area Surface Burned for each Area Classification Factor as shown on the Cosmetic Burns Schedule, and as determined by the attending Physician; and
3. steps 1 and 2 above determine a percentage, which is then multiplied by the Cosmetic Disfigurement From Burns Principal Sum as shown on the *Policy Schedule of Benefits.*

[This benefit will be paid in addition to any other benefit payable under this Policy with the exception of a benefit paid under the Dismemberment, Loss of Speech or Hearing Benefit for the same area burned.**]**

If an Insured Person suffers burns in more than one area as a result of any one Covered Activity, the calculation above shall be performed for each burned area. The maximum amount payable under this benefit shall not exceed 100% of the Cosmetic Disfigurement From Burns Principal Sum**]**.

Cosmetic Burn Schedule

Body Part	Area Classification Factor	Maximum Allowable Percentage for Area Surface Burned	Percentage of Cosmetic Disfigurement From Burns Principal Sum *
Face, Neck, Head	11	9%	100%
Hand & Forearm (Right)	5	4.5%	22.5%
Hand & Forearm (Left)	5	4.5%	22.5%
Upper Arm (Right)	3	4.5%	13.5%
Upper Arm (Left)	3	4.5%	13.5%
Torso (Front)	2	18%	36%
Torso (Back)	2	18%	36%
Thigh (Right)	1	9%	9%
Thigh (Left)	1	9%	9%
Lower Leg (Right/below knee)	3	9%	27%
Lower Leg (Left/below knee)	3	9%	27%

*The percentage shown is based on 100% of the Body Part identified being burned.**]**

[II.D. PERMANENT PHYSICAL IMPAIRMENT BENEFIT

If an Insured Person suffers a **[**Covered Injury**][**or**][**Covered Illness**]** that results in a Permanent Physical Impairment of a body part, the Company will pay a Permanent Physical Impairment Benefit as shown on the *Policy Schedule of Benefits.*

The amount of the Permanent Physical Impairment Benefit will be determined by the product of the impairment percentage assigned by an examining Physician of Our choice, multiplied by the Permanent Physical Impairment Principal Sum. The impairment value shall be expressed as a percentage, taking into account the body part(s) permanently impaired as that part(s) relates to an Insured Person's whole person. The examining Physician will

determine the impairment percentage by using the American Medical Association's *"Guide to Evaluation of Permanent Impairment"* most current at the time of the claim.

If an Insured Person had a pre-existing physical impairment **[**, or a Heart Permanent Impairment Benefit was paid or is payable for the same condition**]**, the impairment value of the pre-existing physical impairment **[**or Heart Permanent Impairment**]** will be deducted from any impairment value calculated after the **[**Covered Injury**][**or**][**Covered Illness**]** in order to determine the amount of the [Covered Injury] [or] [Covered Illness] Permanent Physical Impairment Benefit that is payable.

If an Insured Person suffers a **[**Covered Injury**][**or**][**Covered Illness**]** that results in over 90% Permanent Physical Impairment, the Company will pay 125% of the Permanent Physical Impairment Benefit as shown on the *Policy Schedule of Benefits*.**]**

[II.E. FELONIOUS ASSAULT BENEFIT
If an Insured Person suffers a **[**Covered Injury**][**or Covered Illness**]** as a result of a Felonious Assault that is directed at the Insured Person while participating in a Covered Activity, the Company will pay an additional benefit as shown on the *Policy Schedule of Benefits* if any of the following benefits are payable for the same **[**Covered Injury**][**or Covered Illness**]**:

- **[**Covered Injury Death Benefit;**]**
- **[**Dismemberment, Loss of Speech or Hearing Benefit**]**;
- **[**Vision Impairment Benefit**]**;
- **[**Cosmetic Disfigurement From Burns Benefit**]**;
- **[**Covered Injury Permanent Physical Impairment Benefit**]**;
- **[**Covered Illness Permanent Physical Impairment Benefit**];**
- **[**Heart Permanent Impairment Benefit**]; [**and**]**
- **[**Paralysis Benefit**]**.

[If an Insured Person suffers a **[**Covered Injury**][**or Covered Illness**]** as a result of a Felonious Assault that is directed at the Insured Person while participating in a Covered Activity, and Insured Person is eligible for Weekly Total **[**or Partial Disability**]** Benefits of **[**12-104**]** consecutive weeks as a result of the same **[**Covered Injury**][**or Covered Illness**]**, beginning after the end of the **[**12^{th} - 104^{th} **]** week the Company will pay an additional weekly benefit **[**equal to **[**10% - 100%**]** of the weekly benefit then payable, subject to the Maximum Benefit Amount**]** shown on the *Policy Schedule of Benefits*.**]**

In no event will the Company pay more than the Maximum Benefit Amount in the *Policy Schedule of Benefits*.
[This benefit is not applicable if the Insured Person is a police officer.**]]**

[II.F. PARALYSIS BENEFIT
If an Insured Person suffers Paralysis resulting from a **[**Covered Injury**][**or**][**Covered Illness**]**, the Company will pay a Paralysis Benefit **[**, provided that the Paralysis occurs within the time period from the **[**Covered Injury**][**or**][**Covered Illness**]** shown on the *Policy Schedule of Benefits***]**. The Benefit Amount is based on the type of Paralysis and shall be equal to the benefit percentage for that type of Paralysis shown below multiplied by the Paralysis Principal Sum shown in the *Policy Schedule of Benefits.*

Paralysis	Benefit Amount
[Quadriplegia	**[**10-200%**]** of the Paralysis Benefit Principal Sum **]**
[Paraplegia	**[**10-200%**]** of the Paralysis Benefit Principal Sum**]**
[Hemiplegia	**[**10-200%**]** of the Paralysis Benefit Principal Sum**]**
[Uniplegia	**[**10-200%**]** of the Paralysis Benefit Principal Sum**]]**

[II.G. IMPAIRMENT MODIFICATION BENEFIT
If, due to Total Disability **[**or Partial Total Disability**]**, an Insured Person sustains a permanent physical limitation or impairment that poses a safety risk or inhibits an Insured Person's ability to maintain independence in his or her current transportation or living situation, the Company will pay the reasonable cost of the following Impairment Modifications:

1. alterations to an Insured Person's residence to make it wheelchair accessible and/or habitable; and
2. modifications necessary to a motor vehicle, owned by an Insured Person, to make the vehicle accessible or operable for an Insured Person.

The Impairment Modifications:
1. must be subject to a written agreement between the Insured Person and the Company which includes the costs and reasons for the modifications;
2. must be incurred within the Impairment Modification Benefit period set forth on the *Policy Schedule of Benefits*
3. **[**do not include charges that would not have been absent insurance;**]** and
4. only include amounts incurred by the Insured Person for which he or she is not reimbursed by another source.**]**

[II.H. HEART PERMANENT IMPAIRMENT BENEFIT
If an Insured Person suffers a Heart Permanent Impairment due to a Covered Illness that results in the Insured Person's Total Disability for at least the amount of time shown on the *Policy Schedule of Benefits*, the Company will pay a benefit.

The benefit due is calculated by multiplying:(1) the Heart Permanent Impairment Benefit Due percentage that corresponds to the Insured Person's highest Left Ventricular Ejection Fraction Percentage and the lowest New York Heart Association Functional Classification and (2) the Heart Permanent Impairment Principal Sum as shown on the *Policy Schedule of Benefits.*

This benefit will be paid in addition to any other benefit payable under this Policy.

Heart Permanent Impairment Chart

Left Ventricular Ejection Fraction Percentage	New York Heart Association Functional Classification	Heart Permanent Impairment Benefit Due
26 to 30% function	Class II	**[**25%**]**Heart Permanent Impairment Principal Sum
26 to 30% function	Class III or IV	**[**50%**]**Heart Permanent Impairment Principal Sum
21 to 25% function	Class II or III	**[**50%**]**Heart Permanent Impairment Principal Sum
21 to 25% function	Class IV	**[**75%**]**Heart Permanent Impairment Principal Sum
Less than 21% function	Class II or III	**[**75%**]**Heart Permanent Impairment Principal Sum
Less than 21% function	Class IV	**[**100%**]**Heart Permanent Impairment Principal Sum

[The benefit is further modified by the Insured Person's age on the date of the heart impairment, according to the following table:

- Age **[**40**]** or less **[**10-200%**]** of the amount payable
- Age**[**41**]** to 65 **[**10-100%**]** of the amount payable
- Age**[**66**]** or over **[**10-100%**]** of the amount payable**]]**$_{10}$

[Section III: INCOME PROTECTION BENEFITS

[III.A WEEKLY TOTAL DISABILITY BENEFITS]

[III.A.I. COVERED INJURY MINIMUM WEEKLY TOTAL DISABILITY BENEFIT

If an Insured Person is Totally Disabled as the result of a Covered Injury, the Company will pay the Minimum Weekly Benefit Amount shown on the *Policy Schedule of Benefits*, **[**provided that 1) the Insured Person's Total Disability occurred within the time period shown on the *Policy Schedule of Benefits*; and 2) the Total Disability lasted for a period exceeding the Waiting Period shown on the *Policy Schedule of Benefits*.**]**The Weekly Total Disability Benefit shall be payable for a period up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Injury.

[If an Insured Person is approved for disability retirement or otherwise retires, all eligibility for Total Disability terminates on the effective date of such retirement.**]]**

[III.A.ii. COVERED ILLNESS MINIMUM WEEKLY TOTAL DISABILITY BENEFIT

If an Insured Person is Totally Disabled as the result of a Covered Illness, the Company will pay the Minimum Weekly Benefit Amount shown on the *Policy Schedule of Benefits*, **[**provided that 1) the Insured Person's Total Disability occurred within the time period shown on the *Policy Schedule of Benefits*; and 2) the Total Disability lasted for a period exceeding the Waiting Period shown on the *Policy Schedule of Benefits*.**]**The Weekly Total Disability Benefit shall be payable for a period up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Illness.**]**

[If an Insured Person is approved for disability retirement or otherwise retires, all eligibility for Total Disability terminates on the effective date of such retirement.**]]**

[III.A.iii. COVERED INJURY WEEKLY EARNED INCOME REPLACEMENT BENEFIT

If an Insured Person is Totally Disabled as a result of a Covered Injury and the Minimum Weekly Total Disability Benefit Amount is being paid, the Company will pay a Covered Injury Weekly Earned Income Replacement Benefit **[**provided that 1) the Insured Person's Total Disability occurred within the time period shown on the *Policy Schedule of Benefits*; and 2) the Total Disability lasted for a period exceeding the Waiting Period shown on the *Policy Schedule of Benefits**]***. The amount of the Covered Injury Weekly Earned Income Replacement Benefit shall be computed as follows:

the Insured Person's Weekly Earned Income less the combined total of:

a. the Covered Injury Minimum Weekly Total Disability Benefit Amount; and
b. the Loss of Earnings Coverage.

In no event will the Covered Injury Weekly Earned Income Replacement Benefit exceed the Maximum Weekly Benefit Amount shown on the *Policy Schedule of Benefits.*

The Covered Injury Weekly Earned Income Replacement Benefit will be paid for the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Injury.

[If an Insured Person is approved for disability retirement or otherwise retires, all eligibility for Total Disability terminates on the effective date of such retirement.**]]**

[III.A.iv. COVERED ILLNESS WEEKLY EARNED INCOME REPLACEMENT BENEFIT

If an Insured Person is Totally Disabled **[**and the Covered Illness Minimum Weekly Total Disability Benefit is being paid,**]** the Company will pay a Covered Illness Weekly Earned Income Replacement Benefit **[**provided that 1) the Insured Person's Total Disability occurred within the time period shown on the *Policy Schedule of Benefits*; and 2) the Total Disability lasted for a period exceeding the Waiting Period shown on the *Policy Schedule of Benefits***]**. The amount of the Covered Illness Weekly Earned Income Replacement Benefit shall be computed as follows:

the Insured Person's Weekly Earned Income less **[**the combined total of:**]**

a. the Covered Illness Minimum Weekly Total Disability Benefit Amount; and
b. the Loss of Earnings Coverage.

In no event will the Covered Illness Weekly Earned Income Replacement Benefit exceed the Maximum Weekly Benefit Amount shown on the *Policy Schedule of Benefits.*

The Covered Illness Weekly Earned Income Replacement Benefit will be paid for the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Illness.

[If an Insured Person is approved for disability retirement or otherwise retires, all eligibility for Total Disability terminates on the effective date of such retirement.**]]**

[III.B. PARTIAL DISABILITY BENEFIT

If an Insured Person suffers a **[**Covered Injury**][**or**][**Covered Illness**]** that results in a Partial Disability, the Company will pay a Partial Disability Benefit as provided on the *Policy Schedule of Benefits* if**[**, after a period of Total Disability for which Income Protection Benefits are paid,**]** an Insured Person returns to any **[**occupation**][**Reasonable Occupation**]** at lower rate of Weekly Earned Income than he or she was earning prior to becoming **[**Totally Disabled**][**Partially Disabled**]**.

The Weekly Benefit Amount shall be computed as follows:

the Insured Person's Weekly Earned Income less the combined total of:

a. earnings from any **[**occupation**][**Reasonable Occupation**]**; and
b. the Loss of Earnings Coverage.

In no event will the Partial Disability Benefit exceed the Maximum Weekly Benefit Amount shown on the *Policy Schedule of Benefits.*

[The Partial Disability Benefit will be paid for the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Partially Disabled as a result of the **[**Covered Injury**][**or**][**Covered Illness.**]**

[If an Insured Person is approved for disability retirement or otherwise retires, all eligibility for Partial Disability terminates on the effective date of such retirement.**]]**

[III.C. COST OF LIVING ADJUSTMENTS

After each Review Date, the Company will make Cost of Living Adjustments as set forth below:

[If only the **[**Covered Injury **[**and/or**]** Covered Illness**]** Minimum Weekly Total Disability Benefit **[**is/are**]** payable, the Company will increase the benefit then payable by the **[**greater**][**lesser**]** of (a) **[**1-10**]** % or (b) the **[**CPI-U**]** at the time. In no event will the increase exceed **[**1-10%.**]]**

[If the **[**Covered Injury **[**and/or**]** Covered Illness**]** Minimum Weekly Total Disability Benefit and the **[**Covered Injury **[**and/or**]** Covered Illness**]** Weekly Earned Income Replacement Benefits are payable, the Company will increase the combined benefit then payable by the **[**greater**][**lesser**]** of (a) **[**1-10**]** % or (b) the **[**CPI-U**]** at the time, of the Weekly Earned Income at the time the Insured Person's Disability began. In no event will the increase exceed **[**1-10%.**]]**

[If, for 52 consecutive weeks, disability benefits are payable through a combination of the **[**Covered Injury **[**and/or**]** Covered Illness**]** Minimum Weekly Total Disability Benefit, **[**Covered Injury [and/or] Covered Illness**]** Weekly Earned Income Replacement Benefit, Partial Disability Benefits, or only Partial Disability Benefits, the Company will increase the average weekly benefit paid during the prior 52 weeks by the **[**greater**][**lesser**]** of (a) **[**1-10**]** % or (b) the **[**CPI-U**]** at the time. In no event will the increase exceed [1-10%].]

These adjustments will be made after each Review Date and will be compounded. Any increased benefits apply to the 52 weeks of continuous disability immediately following the date of adjustment. In no event will any computed benefit exceed **[** the Maximum Benefit Amount**] [[**two (2); three (3)**]** times the Maximum **[**Covered Injury **[**and/or**]** Covered Illness**]**Weekly Total Disability Benefit Amount**]**shown on the *Policy Schedule of Benefits.***]**

[III.D. FIRST WEEK TOTAL DISABILITY BENEFIT

For the first week that an Insured Person is Totally Disabled due to a **[**Covered Injury**][**or**][**Covered Illness**]**,the Company will pay a First Week Disability benefit that shall be computed as follows:

the Insured Person's Weekly Earned Income less the combined total of:

a. the **[**Covered Injury**][**or**][**Covered Illness**]**Minimum Weekly Total Disability Benefit;
b. the **[**Covered Injury**][**or**][**Covered Illness**]**Weekly Earned Income Replacement Benefit; and
c. Loss of Earnings Coverage.

In no event will the First Week Total Disability Benefit exceed the Maximum First Week Disability Benefit Amount shown on the *Policy Schedule of Benefits.*

To the extent that the calculation above results in no loss of Weekly Earned Income, no First Week Total Disability Benefit will be payable. This benefit shall be payable based on actual loss of Weekly Earned Income per day not to exceed the First Week Disability Benefit shown on the *Policy Schedule of Benefits.***]**

[III.E. WEEKLY PERMANENT PHYSICAL IMPAIRMENT BENEFIT

If, due to a **[**Covered Injury**][**or**][**Covered Illness**]** for which the Insured Person is receiving Weekly Total Disability Benefits **[**or Partial Disability Benefits**]**, the Insured Person has a Permanent Physical Impairment percentage of **[**10-50%**]** or greater (as described in the paragraph below), the Company will pay a benefit, up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits*.

The amount of the benefit will be determined by multiplying the Weekly Total Disability Benefit **[**or Partial Disability Benefit**] [**payable during the last week of eligibility**] [**payable at the end of the Benefit Period for which Weekly Total Disability Benefits **[**or Partial Disability Benefits**]** are payable**]** by the impairment percentage assigned by an examining Physician of Our choice. The impairment value shall be expressed as a percentage, taking into account the body part(s) permanently impaired as that part(s) relates to an Insured Person's whole person. The examining Physician will determine the impairment percentage by using the American Medical Association's *"Guide to Evaluation of Permanent Impairment"* most current at the time of the claim.

This benefit will begin during the first week after Weekly Total Disability Benefits **[**or Partial Disability Benefits**]** are no longer payable, and will continue to be paid for **[** the Maximum Benefit Period shown on the *Policy Schedule of Benefits***] [**the remainder of the Insured Person's lifetime**]**. This benefit will be paid in addition to any benefits paid or payable under the Policy.

[If an Insured Person had a pre-existing physical impairment prior to the **[**Covered Injury**][**or**][**Covered Illness**]**, the impairment value of the pre-existing physical impairment will be deducted from the impairment value calculated after the **[**Covered Injury**][**or**][**Covered Illness**]** in order to determine the amount of the Weekly Permanent Physical Impairment Benefit.**]]**

[III.F. TRANSITION BENEFIT

If an Insured Person is given a release to return to his or her primary employer after having received **[**Weekly Total Disability Payments **[**, Earned Income Replacement Weekly Total Disability Payments, or Partial Disability Payments**]]** under this Policy for a **[**Covered Injury**][**or**][**Covered Illness**]**, but his or her primary employer has terminated his or her employment due to the **[**Covered Injury**][**or**][**Covered Illness**]** that led to the Total Disability **[**or Partial Disability**]**, the Company will continue to pay disability benefits previously payable under this Policy for a period of up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits* while an Insured Person actively seeks employment.**]**

[III.G RETRAINING BENEFIT

If**[**, after receiving benefits under the Occupational Rehabilitation Benefit of this Policy,**] [**or vocational rehabilitative services through Other Valid and Collectible Insurance,**]** an Insured Person as a result of a **[**Covered Injury**][**or**][**Covered Illness**]** cannot find and maintain a Regular Occupation, the Company will pay for the Insured Person to enroll in an institution of higher learning or professional or trade training program, subject to the following conditions:

- the Company must approve the program in advance, which must be designed to teach or train the Insured Person with skills to obtain a Reasonable Occupation;
- the Company and Insured Person must enter into a written agreement detailing the program, costs and expected progress of the Insured Person; **[**and**]**

- the Company will review the program and the progress of the Insured Person at the end of each of the institution's term and will only continue to pay for the program if it meets the goals set out at the beginning of the program**[**; and
- this benefit is only available after the Insured Person is Totally Disabled for **[**26 weeks–10 years**]** .**]**

The Company shall pay the actual costs incurred by the Insured Person for tuition, books and supplies charged by the institution up the Maximum **[**Annual**]** Benefit Amount shown on the *Policy Schedule of Benefits* **[**for a period of time not exceed the Maximum Benefit Period shown in the *Policy Schedule of Benefits***]**. The Company shall not pay for expenses incurred by the Insured Person for which he or she is reimbursed by another source.

Participation in the program by an Insured Person will not, in and of itself, be considered a recovery from a **[**Total **[**Disability**][**Partial Disability**]**. Benefits for disability will continue as provided by the Policy while an Insured Person is actively participating in the program.**]**[11]

[EXCLUSIONS THAT APPLY TO THE INCOME PROTECTION BENEFITS:
In addition to the Exclusions provided under the Policy, no Income Protection Benefits shall be payable in the following instances, unless coverage is specifically provided:

[1. During the Insured Person's incarceration in a penal or corrections institution. Payments may resume after incarceration as long as the Insured Person remains Totally Disabled and remains covered under the Policy;**]**
[2. the Insured Person's inability to perform his or her Regular Occupation due to the revocation, restriction or non-renewal of an Insured Person's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to **[**Covered Injury**][**or**][**Covered Illness**]** otherwise covered by the Policy;**]** and
[3. the Insured Person is not receiving **[**and conforming to**]**Appropriate Care.**]]**[12]

[LIMITATIONS
1. Total Disability **[**or Partial Disability**]** claims resulting from athletic events that are not Organized League Athletic Events will be limited to a maximum period of up to **[**26-260**]** weeks.
2. In no event will benefits be payable to an Insured Person for more than one disability at the same time.
3. An Insured Person may reopen his or her claim at any time up to **[**1-10**]** years following a period of Total Disability or Partial Disability for either Covered Injuries or Covered Illnesses for which payments were made under this Policy.
4. If an Insured Person is covered by multiple Accident Policies issued by the Company, the total amount of Income Protection Benefits payable under all policies will be a weekly benefit amount up to a maximum of **[**$10-$10,000**].]**[13]

[Section IV: MEDICAL EXPENSE BENEFITS

[IV.A. MEDICAL EXPENSE BENEFIT

The Company will pay 100% of the Reasonable and Customary Charges for the Covered Medical Expenses incurred by an Insured Person as a result of a **[**Covered Injury**][**or**][**Covered Illness**]**. The amount payable will be subject to the following conditions and limitations:

- **[**Covered Medical Expenses shall only become payable when the Medical Expense Deductible, if any, has been met.**]**
- **[**Covered Medical Expenses shall only become payable when the Medical Expense Policy Aggregate Deductible, if any, has been met.**]**
- The Company shall not pay more than the Maximum Medical Expense Benefit Amount shown on the *Policy Schedule of Benefits* for all Covered Medical Expenses resulting from the same **[**Covered Injury**][**or**][**Covered Illness**]**.
- **[**The Company may have a different Medical Expense Deductible and Maximum Medical Expense Benefit Amount depending on whether the Covered Medical Expenses result from a Covered Injury or Covered Illness. The different amounts, if any, are contained on the *Policy Schedule of Benefits**].***
- **[**The Company may impose limits on certain types or categories of Covered Medical Expenses .These limits, if any, are contained in the *Policy Schedule of Benefits.***]**
- **[**This benefit is in excess over Other Valid and Collectible Insurance. If an Insured Person receives or is entitled to receive benefits for Covered Medical Expenses under Other Valid and Collectible Insurance, this Policy will be in excess of the amount of such insurance.**]**

[IV. B. PLASTIC SURGERY EXPENSE BENEFIT

If the Insured Person incurs expenses that exceed the Maximum Medical Expense Benefit Amount provided under the Medical Expense Benefit as shown on the *Policy Schedule of Benefits*, the Company shall provide an additional amount for Covered Medical Expenses incurred for plastic surgery that is Medically Necessary due to a **[**Covered Injury**][**or**][**Covered Illness**]**. The additional amount is a percentage of the Maximum Medical Expense Benefit Amount provided under the Medical Expense Benefit and is shown on the *Policy Schedule of Benefits.* **]**[14]

[EXCLUSIONS FOR MEDICAL EXPENSE BENEFIT AND THE PLASTIC SURGERY EXPENSE BENEFIT

In addition to the Exclusions provided under the Policy, no Medical Expense Benefit or Plastic Surgery Expense Benefits shall be payable for the following treatments or services, unless coverage is specifically provided:

[1. benefits paid or payable under any Workers' Compensation Act or similar law, or under any no fault automobile insurance plan. If an Insured Person settles a Workers' Compensation claim, including medical expenses under Workers' Compensation, medical expenses rising form the injury or occupational disease that led to the Workers' Compensation claim will be deemed to be payable under Workers' Compensation for purpose of determining Covered Medical Expenses;**]**
[2. blood, blood plasma, or blood storage, except expenses by a Hospital for processing or administration of blood;**]**
[3. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;**]**
[4. any elective or routine treatment, surgery, health treatment, or examination, includ**i**ng any service, treatment or supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;**]**
[5. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;**]**
[6. treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;**]**
[7. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;**]**
[8. rest cures or custodial care;**]**
[9. repair or replacement of existing dentures, partial dentures, braces or bridgework;**]**
[10. personal services such as television and telephone or transportation;**]**
[11. expenses payable by any automobile insurance policy without regard to fault;**]**
[12. treatment or service provided by a private duty Nurse;**]**
[13. repair or replacement of existing artificial limbs, eyes and larynx;**]**
[14. treatment of Hernia of any kind. Hernia means a rupture or protrusion of an organ or part through connective tissues or through a wall of a cavity in which it is normally enclosed;**]**
[15. chiropractic treatment;**]**
[16. charges for any article of clothing intended for use more than once;**]**

[17. treatment of an injury resulting from or contributed to by fainting or seizures, or heatstroke or heat exhaustion.**]**

Other exclusions that apply to this benefit are in the General Exclusions section.**]**[15]

[Section V: ADDITIONAL BENEFITS

[V.A. DAILYHOSPITAL CONFINEMENT [AND/OR][OUTPATIENT TREATMENT] BENEFIT

If, due to a **[**Covered Injury**][**or**][**Covered Illness**]**, an Insured Person is admitted to a Hospital on an Inpatient patient basis, the Company will pay the Daily Benefit Amount shown on the *Policy Schedule of Benefits* for each full day an Insured Person is confined as an Inpatient to the Hospital. The number of days payable under this benefit will not exceed the Maximum Benefit Period for Hospital confinement shown on the *Policy Schedule of Benefits*.**]**

[Treatment after Discharge

If, after a period of being confined as an Inpatient in a Hospital due to a **[**Covered Injury**][**or**][**Covered Illness**]**, an Insured Person requires Outpatient physical therapy, rehabilitation and/or follow-up Physician visits for the treatment of the **[**Covered Injury**][**or**][**Covered Illness**]**, the Company will pay the Daily Benefit Amount for each day of such Outpatient treatment. The number of days payable under this benefit will not exceed the Maximum Benefit Period for treatment after discharge shown on the *Policy Schedule of Benefits*. The Company will only make one payment per day, regardless of the number of appointments an Insured Person attends on any given day.**]**

[Treatment Without Hospital Confinement

If, due to a **[**Covered Injury**][**or**][**Covered Illness**]**, an Insured Person does not require confinement as an Inpatient in a Hospital, but does require Outpatient physical therapy, rehabilitation and/or follow-up Physician visits, the Company will pay the Daily Benefit Amount shown on the *Policy Schedule of Benefits* for each day of such Outpatient treatment. The number of days payable under this benefit will not exceed the Maximum Benefit Period for treatment without Hospital confinement shown on the *Policy Schedule of Benefits*. The Company will only make one payment per day, regardless of the number of appointments an Insured Person attends on any given day.**]]**

[V.B. DAILY CRITICAL CARE BENEFIT

If, due to a **[**Covered Injury**][**or**][**Covered Illness**]**, an Insured Person is Hospital confined to an intensive care, trauma, critical care, burn or similar specialty unit, the Company will pay the Daily Benefit Amount shown in the *Policy Schedule of Benefits* for each full day of such confinement. The number of days payable under this benefit will not exceed the Maximum Benefit Period shown on the *Policy Schedule of Benefits*.**]** This payment is in lieu of the Daily Hospital Confinement Benefit.**]**

[V.C. FAMILY EXPENSE BENEFIT

If, as a result of a **[**Covered Injury**][**or**][**Covered Illness**]**, an Insured Person requires medical treatment that causes an Immediate Family Member or a significant other to accompany an Insured Person for treatment or to help treat an Insured Person, the Company will pay the following reasonable expenses actually incurred by the Immediate Family Member or significant other and not reimbursed by another source: loss of wages, out of pocket expenses, hotel accommodations, parking, childcare or other expenses reasonably related to treatment or care of the Insured Person. The most the Company will pay under this benefit is the Maximum Family Expense Benefit Amount shown on the *Policy Schedule of Benefits*.**]**

[V.D. SURVIVING SPOUSE EDUCATION BENEFIT

If an Insured Person suffers a **[**Covered Injury Death**][**or**][**Covered Illness Death**]**, the Company shall reimburse the surviving Spouse expenses incurred to enroll in an institution of higher learning or professional or trade training program, subject to the following conditions:

- The Company must approve the program in advance, which must be designed to teach or train the Spouse with the skills necessary to work in an occupation after the completion of the program;
- The Company and Spouse must enter into a written agreement detailing the program, costs and expected progress of the Insured Person;
- The Company will review the program and the progress of the Spouse at the end of each of the institution's term and will only continue to pay for the program if it meets the goals set out at the beginning of the program;
- This Spouse must begin the program within **[**1-2 years**]** of the Insured Person's death.

The Company shall reimburse the Spouse at the end of each year for tuition, books and supplies charged by the institution up the Maximum Annual Benefit Amount shown on the *Policy Schedule of Benefits* for a period of time not exceed the Maximum Benefit Period or Maximum Benefit Amount shown in the *Policy Schedule of Benefits*. The Company shall not pay for expenses incurred by the Insured Person for which he or she is reimbursed by another source.**]**

[V.E. OCCUPATIONAL REHABILITATION BENEFIT

If an Insured Person is receiving Weekly Total Disability Benefits **[**or Partial Disability Benefits**]**, he or she may be eligible for a rehabilitation program. The Company will pay up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* for the program as set forth in a written agreement. The goal of the rehabilitation program will be to return an Insured Person to the workforce in a Reasonable Occupation for which he or she is reasonably suited considering the **[**Covered Injury**][**or**][**Covered Illness**]** sustained.

The Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other services. The other services and expenses that might be provided may include:

- coordination of physical rehabilitee and medical services;
- financial and business planning;
- vocational evaluation and transferable skills analysis;
- career counseling and retraining;
- labor market surveys and job placement services; and
- evaluation of necessary worksite modifications and adaptive equipment and may include work on a part time basis.

The Company can periodically review the program and an Insured Person's progress. The Company will continue to pay for the program as long as the Company determines that the program is helping an Insured Person return to the workforce.

An Insured Person's participation in a rehabilitation program will not, in and of itself, be considered a recovery from **[**Total Disability**][**or Partial Disability**]**. Benefits for Weekly Total Disability **[**or Partial Disability**]** will continue as provided by the Policy while an Insured Person is actively participating in the program.**]**

[V.F. MENTAL STRESS MANAGEMENT BENEFIT

If an Insured Person suffers psychiatric or mental stress as a direct result of either being actively engaged in a single emergency incident or repeated active engagement in emergency incidents as a member of the **[**Sponsoring Organization**]**, the Company will pay the Reasonable and Customary amounts for Physician services to treat the psychiatric or mental stress, subject to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits,* provided that the Physician is properly licensed to provide such care and the care is appropriate for the condition causing the psychiatric or mental stress.**]**

[V.G. TRAUMATIC INCIDENT BENEFIT

The Company will pay the reasonable expenses for the services provided by a Traumatic Incident Stress Management Team if such services are requested and authorized by the **[**Sponsoring Organization**]** as a result of a Traumatic Incident. Expenses **[**must be incurred within the time specified on the *Policy Schedule of Benefits* and**]** are subject to the Traumatic Incident Aggregate Maximum Benefit Amount shown on the *Policy Schedule of Benefits*. The Traumatic Incident Aggregate Maximum Benefit Amount is the maximum that will be paid per Traumatic Incident, regardless of the number of Insured Persons treated.**]**

[V.H. HEALTH INSURANCE PREMIUM BENEFIT

If medical or health insurance premiums previously paid by the Insured Person's employer have been discontinued as a result of an Insured Person's**[**Covered Injury**][**or**][**Covered Illness**][**Total Disability**][**or Partial Disability**][**and disability benefits are paid under this Policy,**]** and the Insured Person incurs out of pocket costs for those medical or health insurance premiums, the Company shall pay the amount the Insured Person's employer previously paid for those medical or health insurance premiums,**[**up to the Maximum Annual Benefit Amount**]**each year **[**during the Maximum Benefit Period as shown on the *Policy Schedule of Benefits*.**]** The Company will not pay more than the Maximum Benefit Amount shown on the *Policy Schedule of Benefits*.

[This benefit is not payable if 1) the **[**Sponsoring Organization**]** provides health insurance benefits for the Insured Person or 2) the Insured Person provided and paid for their own health insurance benefits.**]**
[If the Insured Person was responsible for any portion of the medical or health insurance premium prior to the **[**Covered Injury **[**or**]** Covered Illness**]**, that portion of the medical or health insurance premium will not paid under this benefit.**]]**

[V.I. DEPENDENT CHILD EDUCATION BENEFIT

If an Insured Person suffers a **[**Covered Injury Death**][**or**][**Covered Illness Death**]** and a death benefit is payable under this Policy, the Company will pay expenses incurred by each Dependent Child for tuition, fees, books, room and board, transportation and any other costs payable directly to a school, or approved and certified by the school, up to the **[**Maximum Benefit Amount**][**Maximum Annual Benefit Amount**]**shown on the *Policy Schedule of Benefits***.**

[In order to qualify for benefits, a qualifying Dependent Child must:

1. be a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the Insured Person's death [or begin studies as a full-time student at an accredited school of higher learning within [1-2] year of the Insured Person's death and before reaching the limiting age shown in the Dependent Child definition]; and
2. continue His education as a full-time student in such accredited school of higher learning.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian if the child is a minor, at the end of each year **[**up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits**]***. The Company must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a benefit is payable will begin on the first of the month following the date the Insured Person died, if the surviving Dependent Child was a full-time student on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he or she begins studies in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.**]**[16]

a) Childcare Resources/Referrals: BHS shall provide Participants with screened resources for a range of childcare needs within three (3) business days. This service is available to Participants per unique problem episode, per year. Childcare resources include, but are not limited to: day care, emergency care, nurseries, preschools, nanny/au pair, summer camps, adoption and before/after school programs.

b) Eldercare Resources/Referrals: BHS shall provide Participants with screened resources for a range of eldercare needs within three (3) business days. This service is available to Participants per unique problem episode, per year. Eldercare resources include, but are not limited to: in-home care, geriatric specialists, rehabilitation services, screening clinics, and home-based services.

c) Legal Consultation Services: BHS provides telephone access to attorneys. Up to a 30-minute telephonic or face to face legal consultation are available to Participants per unique problem episode, per year. If the Participant needs to retain an attorney a referral will be provided to them, in addition to a 25% discount on any further services. Referrals are made to local, pre-screened and credentialed attorneys.

d) Financial Consultation Services: BHS provides telephone access to financial counselors within one (1) business day. An unlimited number of telephonic financial consultations are available to Participant. Referrals made to local, pre-screened and appropriately credentialed financial counselors for additional assistance are also provided.

11) Account Management: BHS shall assign Customer a primary point of contact to oversee the execution of the services outlined herein.

12) Online Resources: Participants will have access to outsourced web-based resources provided by Responders 1stCall.com.

13) Service Promotion: BHS will provide an announcement letter with service details, a summary of services promotional flyer, a virtual wallet card, special crisis communications when warranted and as needed tip sheets and educational materials when requested. Such materials will be subject to prior approval by Customer and BHS. All materials will be provided in electronic format for Customer to disseminate to Participants.

BHS shall not use the logo, website address, domain name or service mark of **Customer** or any of its affiliates without the prior written consent of **Customer**. The Administrator shall maintain copies and provide an original to **Customer** of any advertisement or other materials approved by **Customer** along with full details concerning where, when and how it was used.

14) Reporting: BHS shall provide service utilization reports to Customer on a monthly basis. Reports will be in a format mutually agreed upon by BHS and Customer. The reporting will include utilization and program activity data. Data will be reported so as to protect the identity of all Participants.

2. Traumatic Incident Stress Management

1) Traumatic Incident Consultation and Response: BHS will provide consultation to Customer's policyholders after traumatic incidents to assist with determining and planning for the appropriate response or intervention. At the request of Customer's policyholder, BHS will provide telephonic outreach to impacted Participant's or their family members or provide telephonic or video based defusings, debriefings and/or stress reduction education for groups of impacted Participants. For each request after the twenty-five (25) hours per year have been exhausted, BHS will obtain written authorization from Customer prior to delivering any additional consultation and response services. Additional telephonic consultation and outreach to impacted Participants will be billed at the rate of $150.00 per hour. HIPAA compliant, video-based response services such as defusing or debriefings for small groups of impacted Participants will be billed at $275.00 per hour.

2) Onsite Support: After consultation with the policyholder and after written authorization from Customer, BHS is available to deploy professionals trained in critical incident stress management onsite to a policyholder's location to provide in-person, one-on-one support, grief and loss group sessions, defusings, debriefings, stress reduction education sessions or other services to assist in the aftermath of or preparation for future a traumatic incidents. All onsite services will be billed at the rate of $375.00 per hour per professional.

PET HEALTH INSURANCE POLICY
TERMS AND CONDITIONS

SAMPLE

AXIS Insurance Company
Administered by Fetch Insurance Services, LLC
For questions concerning your policy, call 1.866.467.3875
©2023 Fetch Insurance Services, LLC

INDEX OF POLICY

SAMPLE

 © 2023 Fetch Insurance Services, LLC

I. DEFINITIONS USED THROUGHOUT THIS POLICY

Some words or phrases in the **policy** have been defined below. Defined words or phrases are printed in bold type and have the following meanings, unless a different meaning is described in a particular coverage or endorsement.

You, Your	The named insured as shown on the **declarations page**, and the spouse or partner, if residing at the same address.
We, Us, Our	The company providing this insurance, or the company's designated representative.
Pet, Your Pet	Any dog or cat named and described on the **declarations page** and for which a premium has been paid.
Behavioral Disorder(s)	Any change in **your pet's** temperament, activity or inactivity that is abnormal, dysfunctional or unusual for which there is no underlying **medical condition(s)**. **Behavioral disorders** include, but are not limited to, aggression, separation anxiety or phobias.
Clinical Sign(s)	Changes in **your pet's** normal healthy state, its bodily functions or behavior (as observed by any individual, recorded in **your pet's** medical record, or identified in previously performed examinations or **treatment(s)** for **your pet**).
Co-pay(s)	The percentage of **your** claim for which **you** are liable before any applicable **deductible** is applied.
Congenital Defects Abnormalities	Any condition(s), abnormality(ies) or disorder(s) present at and existing **or** from the birth of **your pet.**
Curable Medical Condition	Any medical condition or **injury** that can be completely resolved without recurrence or any manifestations of **clinical signs**.
Curable Exclusionary Period	There is a three hundred sixty-five (365) day exclusionary period for any **curable medical condition** that is observed, recorded, or identified up to three hundred sixty-five (365) days prior to the **original inception date** of the **policy**, during the **waiting period,** or during **your pet's first exam**. A second three hundred sixty-five (365) day exclusionary period will apply if the **curable medical condition** reoccurs within the first three hundred sixty-five (365) days after the **original inception date** of the **policy**. If the same **curable medical condition** reoccurs during the second exclusionary period, then it will be excluded from coverage for the life of **your pet**.
Declarations Page	A written document comprising part of this **policy** which identifies the named insured, **policy** number, insured **pet**, insured coverage options selected, **policy period**, any applicable **co-pay(s)** and/or **deductible(s)** and the **maximum annual policy coverage** provided.

SAMPLE

 © 2023 Fetch Insurance Services, LLC

Deductible(s)	The fixed amount per **policy period** for which **you** are liable prior to receiving any claims settlement that will be deducted from any reimbursement made to **you**, after any **co-pay** amount has been deducted.
Excess Insurance	Reimbursement under this **policy** will only be available once limits for coverage under any other **policy** have been exhausted.
Exclusion(s)	Any situation, event or **medical condition** not covered by this **policy**.
Experimental Treatment	Drugs, therapies, or **treatments** that are unproven, have been confined largely to laboratory use, or have progressed to limited **pet** application and trials, and lack wide recognition from the scientific community as a proven and effective measure of **treatment**.
First Exam	The earliest exam performed by a **veterinarian** after the effective date of the **policy**, but during the **policy period** if **your pet** has not been examined by a **veterinarian** within six (6) months prior to the effective date of the **policy**.
Holistic Therapy	Any **treatments** including but not limited to acupuncture, aromatherapy, chiropractic, and homeopathic therapy administered by a **veterinarian** to treat an **injury** or **illness**.
Illness(es)	Any change to the normal healthy state of **your pet** such as a sickness, disease or **medical condition** (except **behavioral disorders**) not caused by an accident.
Injury(ies)	Physical harm to **your pet** caused by normal activity or an accident.
Maximum Annual Policy Coverage	The most **we** reimburse during the **policy period** for each type of insured coverage covered by this **policy** as shown on the **declarations page**.
Medical Condition(s)	All **clinical sign(s)** and symptoms resulting from the same diagnostic classification or disease process, regardless of the number of **illnesses** or **injuries** or areas of the body affected.
Medically Necessary	Any **treatment** or procedure which is directly and materially related to a covered **illness** or **injury**, as recommended and documented in **your pet's** medical records by the treating **veterinarian**.
Original Inception Date	The first **policy period** effective date with **us** for **your pet** where continuous coverage has been provided without interruption. Any lapse or gap in coverage will reset the date to the next **policy period** effective date after the lapse or gap in coverage.
Physical Therapy	Any **treatment** including but not limited to hydrotherapy, laser, underwater treadmill, kinesiotherapy, land-based exercise, massage, stretching, electrical stimulation administered by a **veterinarian** to treat an **injury** or **illness**.

SAMPLE

 © 2023 Fetch Insurance Services, LLC

Policy	All **terms and conditions** of this **policy** and any endorsements thereto including the **declarations page.**
Policy Period(s)	The period from the effective date to the expiration date of the **policy** as set forth on the **declarations page**.
Pre-existing Condition(s)	A **medical condition** which first occurred or showed **clinical sign(s)** before the effective date of this **policy** or which occurred or showed **clinical sign(s)** during the **policy waiting period**, or during **your pet's first exam**.
Preventive Care	Any **treatment**, service or procedure, including but not limited to physical examinations, medications, surgeries, inoculations or laboratory procedures, for the purpose of prevention of **illness** or **injury** or for the promotion of general health, where there has been no **injury** or **illness**.
Reasonable Cost(s)	The fees regularly charged for a given **treatment, sick visit fee,** or procedure by the treating veterinary facility, or the fee regularly charged by a licensed kennel or cattery.
Sick Visit Fee	The **veterinarian** examination cost for treating **your pet's injury** or **illness.**
Supplements	Any medicinal substance including but not limited to nutraceuticals, vitamins, and herbal medicines not requiring a prescription that a **veterinarian** recommends for the treatment of an **injury** or **illness**.
Telehealth Treatment	Any **treatment** administered by a **veterinarian** to treat any **injury** or **illness** by means of remote telecommunications technology including but not limited to phone, email, Internet, text and video.
Terms and Conditions	All provisions of this **policy**.
Treatment(s)	Any veterinary care and prescribed medications administered by a **veterinarian**, or under a **veterinarian's** direct supervision, in treating **your pet's injury** or **illness,** within the United States or Canada.
Veterinarian	Any licensed **veterinarian** residing and practicing within the United States or Canada from whom **your pet** has received **treatment**.
Waiting Period	There is a fifteen (15) day period beginning on the effective date of this **policy** during which **we** will not cover any **injury, illness, behavioral disorder or any other coverage provided by this policy.** The **waiting period** will not apply to any renewal of **your policy** if renewal coverage is continuously maintained. **Medical conditions** for which **clinical sign(s)** were observed during the **waiting period** are excluded from this **policy** as **pre-existing conditions**. (See also Section V.e.)
Working Dog	Any dog used for occupational, professional, or business use.

SAMPLE

 © 2023 Fetch Insurance Services, LLC

II. INSURING AGREEMENT

Upon **your** payment of the premium when due, and in reliance on the statements **you** made, **we** will provide coverage as specifically described in and subject to the **terms and conditions** of this **policy** for **your** covered **pet**.

Except if stated to the contrary, all insured coverages are subject to all the **terms, conditions** and limitations as stated herein and as shown on the **declarations page**.

III. INSURED COVERAGES

We will provide the coverages to **you** as set forth in the paragraphs below subject to the following:

- **Waiting period**.
- **Co-pay(s)**.
- **Deductible(s)**.
- **Exclusions**.
- Limits of insurance.
- Other **terms, conditions** and limitations in this **policy**.

A. POLICY COVERAGE

1. VETERINARY FEES, PRESCRIBED DRUGS AND SUPPLEMENTS

We will reimburse **you** for:

a. the **reasonable cost(s)** of any **medically necessary treatment** administered by a **veterinarian** within the United States or Canada that **your pet** has received during the **policy period** for a covered **illness** or **injury**;

b. the **medically necessary reasonable cost** of pharmaceuticals that can only be obtained by means of a **veterinarian** prescription to treat an **illness**, **injury**, or **behavioral disorder** in the quantity of ninety (90) days or less;

c. the **medically necessary reasonable cost** of **supplements**.

The most **we** will pay for this coverage is the **maximum annual policy coverage** shown on **your declarations page**.

2. SPECIAL COVERAGES AND LIMITS

The following coverages do not increase the **maximum annual policy coverage** on **your declarations page** and are not subject to and not considered in applying **co-pay** when **co-pay** conditions otherwise apply. The special coverages are not subject to the applicable **deductible**.

a) BEHAVIORAL FEES AND TELEHEALTH

We will reimburse **you** for;

1. The **reasonable cost(s)** for consultations by a **veterinarian** to diagnose and treat **behavioral disorders** during the **policy period**;
2. The medically necessary reasonable cost of **telehealth treatments** that a **veterinarian** provides to support **treatment** of a covered **injury, illness** or **behavioral disorder**.

This coverage is limited to a $1,000 annual limit.

b) ADVERTISING AND REWARD

We will reimburse **you** for the reasonable and necessary cost of advertising and a reasonable reward paid if **your pet** is stolen or strays during the **policy period**.

This coverage is limited to a $1,000 annual limit.

As soon as **you** discover **your pet** is missing, **you** must:

SAMPLE

 © 2023 Fetch Insurance Services, LLC

1. Notify the police and ask for a reference or case number and written confirmation of **your** report;
2. Notify the five (5) veterinary clinics and animal shelters closest to the area where **your pet** was last seen; and
3. Complete and send us a claim form along with all receipts for costs **you** incurred for advertising and paying a reward.

Conditions Applying to Advertising and Reward

We will not reimburse **you** for:

1. Any reward not supported by a signed receipt giving the full name and address of the person who found **your pet**;
2. Any reward paid to any person living with **you**, related to **you**, employed by **you** or known by **you**; or
3. Any reward resulting from **your** neglect or deliberate concealment of **your pet**.

c) BOARDING FEES

We will reimburse **you** for the **reasonable cost(s)** of boarding **your pet** at a licensed kennel or cattery while **you** are in a hospital as a result of **your** own sickness, disease or bodily **injury** during the **policy period**.

This coverage is limited to a $1,000 annual limit.

You must:

1. Have incurred or have been diagnosed and reported **your** own sickness, disease or bodily injury during the **policy period**;
2. Submit a claim form completed by **your** doctor and the kennel or cattery, as soon as possible after **you** are hospitalized as a result of **your** own sickness, disease or bodily injury; and
3. Submit the original invoice from the kennel or cattery.

Conditions Applying to Boarding Fees

We will not reimburse **you** if:

1. **You** are admitted to a hospital for less than ninety-six (96) hours;
2. **You** are treated in a care setting other than a hospital;
3. **You** are admitted to a hospital because of a sickness, disease or bodily injury, which first occurred or manifested itself before **your pet** was covered under this **policy**;
4. **You** are admitted to a hospital as a result of **your** pregnancy or giving birth;
5. **You** are receiving any treatment that is not related to a sickness, disease or bodily injury; or
6. **You** are admitted to a hospital for the treatment of alcohol abuse, drug abuse, suicide attempt or self-inflicted **illness** or **injury**.

d) LOSS DUE TO THEFT OR STRAYING

We will reimburse **you** for the price **you** paid for **your pet** if **your pet** is stolen or goes missing during the **policy period** and is not found.

This coverage is limited to a $1,000 annual limit.

If **you** have no formal proof of how much **you** paid for **your pet** in the form of an original receipt, **we** will reimburse **you** the lesser of the current local humane society adoption fee for the species of **pet** named on the **declarations page**, or one hundred and fifty dollars ($150). As soon as **you** discover **your pet** is missing, **you** must:

1. Notify the police and ask for a reference or case number and written confirmation of **your** report; and

SAMPLE

 © 2023 Fetch Insurance Services, LLC

2. Notify the five (5) veterinary clinics and animal shelters closest to the area where **your pet** was last seen.
   If **your pet** is not found within thirty (30) days, **you** must complete and send **us** a completed claim form. This must include the original receipt for the price **you** paid for **your pet**.

If **your pet** is found or returns to **you**, **you** must repay the full amount **we** have paid **you** under this **policy** within ninety (90) days of the expiration of the **policy period** in which this benefit was paid or within ninety (90) days of recovering **your pet**.

Conditions Applying to Loss Due to Theft or Straying

We will not reimburse **you** if:

1. **You**, or the person looking after **your pet**, freely parts with **your pet** even if tricked into doing so.

e) DEATH FROM INJURY OR ILLNESS

We will reimburse **you** for the price **you** paid for **your pet**, if **your pet** dies or has to be put to sleep by a **veterinarian** during the **policy period**, as a result of an **injury** or **illness**.

This coverage is limited to a $1,000 annual limit.

If **you** have no formal proof of how much **you** paid for **your pet** in the form of an original receipt, **we** will pay **you** the lesser of the current local humane society adoption fee for the species of **pet** named on the **declarations page**, or one hundred and fifty dollars ($150).

Conditions Applying to Death from Injury or Illness

We will not reimburse **you** if:

1. **Your pet's** death results from an **injury** or **illness** that is a **pre-existing condition**;
2. A **veterinarian** is not able to verify the death or sign the death claim form;
3. **Your pet** was put to sleep at **your** request and not as suggested by a **veterinarian**;
4. The death is the result from an **illness** for any **pet** age six (6) years or older; or
5. **Your pet** was put to sleep because of a **behavioral disorder**.

f) VACATION CANCELLATION

We will reimburse **you** for any travel and accommodation costs **you** cannot recover, if **you** have to cancel or cut short a vacation during the **policy period** because **your pet** is **injured** or shows the first **clinical sign(s)** of an **illness** while **you** are away or up to seven (7) days before **you** leave, and as a result requires immediate lifesaving veterinary **treatment**.

This coverage is limited to a $1,000 annual limit.

Conditions Applying to Vacation Cancellation

We will not reimburse **you** for:

1. Any costs relating to a vacation **you** booked less than twenty-eight (28) days before **you** were due to leave;
2. Any costs resulting from an **injury** or **illness** that is excluded from coverage; or
3. Any cost of cancellation insurance.

SAMPLE

 © 2023 Fetch Insurance Services, LLC

IV. CO-PAY AND DEDUCTIBLES

For any covered loss that is treated during the **policy period, you** are responsible for an amount of **co-pay** and **we** will subtract the **deductible** as stated on **your declarations page** from the covered amount. The **co-pay** percentage will be deducted from the total of all costs for a covered loss. Once the **co-pay** has been applied, the **deductible** will be applied to the remaining amount. When treatment dates of a covered loss fall into two or more **policy periods**, **you** will be responsible for a **deductible** for each **policy period.**

In addition to the application of the **co-pay** and **deductible**, there are total limits on our insurance per **policy period** as set forth on the **declarations page** as **maximum annual policy coverage** limit**.** (See also Section VI.)

V. GENERAL EXCLUSIONS

This **policy** does not cover:

a. Costs **you** incur for **your pet** for any matter not set forth in Section III.
b. Costs and payments beyond the Limits of Insurance as described in Section VI.a.
c. Any cost for treating an **illness** or **injury** incurred outside of the **policy period** while the **policy** is not in force.
d. The portion of the cost of treating an **illness** or **injury** that is greater than the **reasonable cost(s)** for treating such **illness** or **injury**.
e. The cost of any **treatment** or diagnostic testing for **pre-existing conditions** as follows:
    i. Any **injury** that happened or any **illness** that first showed **clinical sign(s)** before the effective date of this **policy**; any **illness** that first showed **clinical sign(s)** during the **waiting period** beginning on the effective date of this **policy**; any **injury** that occurred during the **waiting period** beginning on the effective date of this **policy**.
    ii. Any **injury** or **illness** that is the same as, or has the same diagnosis or **clinical sign(s)** as any **injury**, **illness** or **clinical sign(s) your pet** had prior to the effective date of this **policy**; any **illness** that is the same as, or has the same diagnosis or **clinical sign(s)** as any **illness your pet** had during the **waiting period** beginning on the effective date of this **policy**; or any **injury** that is the same as, or has the same diagnosis or **clinical sign(s)** as any **injury** that occurred to **your pet** during the **waiting period** beginning on the effective date of this **policy**.
    iii. Any **injury** or **illness** that is caused by, relates to or results from any **injury**, **illness** or **clinical sign(s) your pet** had prior to the effective date of this **policy**; any **illness** that is caused by, relates to or results from any **illness** or **clinical sign(s) your pet** had during the **waiting period** beginning on the effective date of this **policy**; or any **injury** that is caused by, relates to or results from any **injury** that occurred to **your pet** during the **waiting period** beginning on the effective date of this **policy**. This exclusion applies no matter where the **injury**, **illness** or **clinical sign(s)** are noticed or occur on **your pet**'s body.
    Pre-existing conditions do not include coverable ongoing **medical conditions** that showed **clinical signs** after the **original inception date** and **waiting period.**
    iv. Any **curable medical condition,** that is observed, recorded or identified up to three hundred sixty-five (365) days prior to the **original inception date** of the **policy** or during the **waiting period** of the **policy,** will be subject to a **curable exclusionary period** of three hundred sixty-five (365) days from the **original inception date** of the **policy**. Any such **curable medical condition** that does not reoccur within the first **curable exclusionary period** will be coverable provided an annual exam is conducted by a **veterinarian** dated after the **curable exclusionary period** and before the first reoccurrence of such **curable medical**

SAMPLE

 © 2023 Fetch Insurance Services, LLC

condition. If the **curable medical condition** does reoccur within the **curable exclusionary period** after the **original inception date** then a second **curable exclusionary period** will apply after the first three hundred sixty-five (365) days. At the end of the second **curable exclusionary period** any such **curable medical condition** that did not reoccur during the second **curable exclusionary period** will be coverable provided an annual exam is conducted by a **veterinarian** dated after the second **curable exclusionary period** and before the second reoccurrence of such **curable medical condition**.

If the same **curable medical condition** reoccurs during the second **curable exclusionary period** it will be excluded from coverage for the life of **your pet.**

f. **Behavioral disorders** where **clinical sign(s)** were apparent prior to the effective date of the **policy** or that became apparent during the **waiting period** beginning on the effective date of this **policy**.
g. **Congenital defects** or **abnormalities** where **clinical sign(s)** were apparent prior to the effective date of the **policy** or that became apparent during the **waiting period** beginning on the effective date of this **policy**.
h. Costs arising out of or related to any **treatment** associated with damage or rupture of cruciate ligaments, luxation of the patellas or other soft tissue disorders of the knee where **clinical sign(s)** occur during the first six (6) months that the policy is in effect. However, coverage will be afforded if **your pet** is examined by a **veterinarian** within the first thirty (30) days after the **original inception date** of the **policy** and the medical record specifically notes **your pet** does not have any **pre-existing conditions** relating to the knees, subject to the **waiting period**.
    i. If **your pet** has received **treatment** or has shown **clinical signs** of a cruciate or soft tissue **injury** to one knee prior to the effective date of this **policy** or during the first 6 months of this **policy**, where no certificate of knee health has been provided as described in section V. h., then the other knee is automatically excluded from coverage.
i. Costs arising out of or related to any **treatment** associated with hip dysplasia where **clinical signs** occur during the first six (6) months that the **policy** is in effect.
j. Intervertebral disc disease when another disc in the same or neighboring spinal region (e.g. cervical, lumbosacral) was previously treated or showing **clinical sign(s)** prior to the effective date of this **policy** or during the **waiting period** beginning on the effective date of the **policy**.
k. Costs arising out of or related to any **treatment** for oral health, including but not limited to dental disease, malocclusions and deciduous teeth, where **clinical sign(s)** (including, but not limited to, tartar, gingivitis, pulp exposure or halitosis) were observed prior to the effective date of the **policy** or during the **waiting period** beginning on the effective date of this **policy**.
l. Food, including food prescribed by a **veterinarian**, to treat or prevent **illness** or **injury**.
m. Any costs and payments for a **pet** less than six (6) weeks old.
n. Any **illness** contracted outside the U.S. or Canada that the **pet** would not have normally contracted in the U.S. or Canada.
o. Costs arising out of or related to:
    i. Breeding;
    ii. Pregnancy;
    iii. Whelping or nursing; or
    iv. **Treatment** of offspring.

SAMPLE

 © 2023 Fetch Insurance Services, LLC

We will reimburse **you** for the **reasonable costs** of **medically necessary treatment** of complications arising from breeding, pregnancy, whelping or nursing if the date of breeding falls after the **waiting period** of the effective date of this **policy.**

p. Bathing **your pet** unless the treating **veterinarian** indicates that bathing was **medically necessary** and that only a **veterinarian** or a member of veterinary staff could bathe **your pet**.
q. Routine and **preventive care**, including but not limited to:
    i. Vaccinations (and vaccine titers and nosodes);
    ii. Preventive medications (including those for heartworm and flea and tick prevention);
    iii. Routine examinations; or
    iv. Dental prophylaxis
    v. **Treatment(s)** and therapies for weight-loss.
r. The cost of boarding **your pet** at a veterinary facility. Hospitalization is a covered expense provided that it is **medically necessary**.
s. The cost of any form of housing, including cages – rented or bought.
t. The cost of renting or purchasing:
    i. A swimming pool;
    ii. A hydrotherapy pool;
    iii. Any other pool or hydrotherapy equipment;
    iv. Any physical therapy devices for in home use (including but not limited to hydrotherapy, laser, underwater treadmill, and/or electric stimulation); or
    v. Beds, orthopedic beds, bedding.
u. Any of the following methods of **treatment** not given by a **veterinarian**:
    i. **Holistic Therapy**; or
    ii. **Physical Therapy**.
v. Experimental **treatments** or any **treatments** or procedures that do not meet the accepted standards of veterinary medicine.
w. Cloned **pets** or cloning procedures, whether or not deemed experimental or for research.
x. Organ transplants not deemed **medically necessary** or not first approved by **us**.
y. Costs and payments arising out of or related to:
    i. Obedience or training classes, including puppy classes;
    ii. Training, correctional devices, or preventive products;
    iii. The **treatment** of coprophagia or other eating disorders; or
    iv. Training for **behavioral disorders**.
z. Grooming, nail clipping, or grooming supplies.
aa. Treatments or preventive **treatments** for parasites or conditions related to parasites (internal or external) unless there is no preventive medication for the parasite including but not limited to:
    i. Heartworms;
    ii. Fleas;
    iii. Ticks;
    iv. Roundworms;
    v. Tapeworms; or
    vi. Hookworms.
bb. Elective or specialty procedures, including but not limited to:
    i. Docking of tails;
    ii. Removal of dewclaws;
    iii. Removal of eyelashes;

SAMPLE

 © 2023 Fetch Insurance Services, LLC

iv. Cropping of ears;
v. Spaying or neutering;
vi. Cosmetic dentistry;
vii. Elective gastropexy; or
viii. Routine/preventive anal gland expression.

cc. Time and travel expenses to a **veterinarian's** premises or hospital.

dd. Costs for **illness** or **injury** arising out of or related to:
i. Racing;
ii. Coursing;
iii. Commercial guarding;
iv. Organized fighting; or
v. Any other occupational, professional or business uses of **your pet**.

ee. Costs and payments arising out of or related to any intentional **injury** or abuse (including persistent neglect) of **your pet**, by **you** or a member of **your** household.

ff. Any costs and payments that arise out of or related to an **injury** or **illness** for which **you** were advised by a **veterinarian** to take action and **you** failed to follow the **veterinarian's** recommendations.

gg. House calls, unless **treatment** is required for a life-saving emergency.

hh. The costs of having **your pet** put to sleep (unless recommended by the treating **veterinarian**), examined or tested post-mortem, cremated or otherwise disposed of. The destruction of a **pet** deemed dangerous is not covered.

ii. Any costs or payments arising out of or related to:
i. Invasion;
ii. War;
iii. Revolt;
iv. Rebellion;
v. Revolution, military or usurped power;
vi. Governmental seizure;
vii. Quarantine; or
viii. Other action related to public safety or health.

jj. The **treatment**, death or humane destruction arising out of or related to Avian Influenza.

kk. Any costs or payments if other General Conditions set forth in Section VII, or conditions applicable to **you** and set forth in Section VIII, have not been met.

ll. Any **treatment** against a **veterinarian's** advice and the subsequent complications as a result, including in circumstances where it is requested by **you** and provided by a **veterinarian**.

mm. Any amount if **you** failed to satisfy, or comply with, the conditions set forth in the GENERAL CONDITIONS, CARE FOR **YOUR PET** (VII.6) section of this **policy,** including, but not limited to, condition b. if **your pet** has not been examined by a **veterinarian** within six (6) months prior to the effective date of the **policy, you** must arrange to have **your pet** examined at **your** own expense within thirty (30) days of the effective date of the **policy**. Any **medical condition(s), clinical sign(s), behavioral disorder(s) or illness(es)** observed or recorded during the **first exam**, and all costs associated therewith, are automatically excluded from coverage. Additionally, any conditions that are related to, caused by, or resulting from **medical condition(s), clinical sign(s), behavioral disorder(s) or illness(es)** observed or recorded at the **first exam** are also excluded from coverage.

SAMPLE

 © 2023 Fetch Insurance Services, LLC

nn. Costs and payments arising out of or related to **physical therapy** and/or **holistic therapy** to treat weight loss**.**

oo. Costs and payments related to shipping, processing and/or handling.

VI. LIMITS OF INSURANCE

a. Regardless of the number of claims made during the **policy period**, the total limit of insurance for each **policy period** for all covered costs and payments shall not exceed the amount shown on the **declarations page** under **maximum annual policy coverage**.

b. All coverage under this **policy** shall cease when **your policy** terminates.

VII. GENERAL CONDITIONS

1. ELIGIBILITY

This **policy** is issued in consideration of:

a. The **declarations page** containing **your policy** elections and other information, a copy of which is attached hereto and made a part hereof; and

b. **Your** payment of premium in the amounts and at the times as stated on the **declarations page**.

2. YOUR DUTIES AFTER LOSS

If **your pet** suffers a loss that may be covered by this **policy**, **you** must:

a. Visit a veterinary clinic within forty-eight (48) hours after first noticing **clinical sign(s)** relating to an **illness** or **injury**.

b. Complete and send to **us** a claim form describing the loss as soon as practicable but no later than ninety (90) days after the date of **treatment**. This form must list the following information:

   i. **Your** name;
   ii. The description of **your pet;**
   iii. **Your policy** number; and
   iv. Description of claimed **illness** or **injury**.

You may also submit claims electronically through **our** online claims submission process.

c. Provide us with copies of invoices from the treating veterinary facility showing:

   i. The **treatments** administered;
   ii. The fees charged; and
   iii. Proof of payment (i.e. receipt and/or invoice showing zero balance due).

d. Otherwise cooperate with **us** in the investigation of any claim which includes providing a complete medical history for **your pet**. Failure to comply with these conditions may result in a claim not being covered.

3. PAYMENT OF LOSS

Once **you** have provided the written notice and other specified information to **us**, **we** will determine whether the loss is covered by this **policy**. **We** will compute any applicable **co-pay** and **deductible(s)**. **We** will then make **our** reimbursement to **you** within thirty (30) days from **our** receipt of all required information. A statement showing the basis for **our** reimbursement will be available through **your** online account or upon request. This will include the effect of the **co-pay** and **deductible** calculations, deducted **exclusion(s)** and any **maximum annual policy coverage**, if applicable.

Reimbursement of one claim does not guarantee **we** will reimburse additional claims. If **we** reimburse **you** for a claim contrary to this **policy's terms and conditions**, that reimbursement does not waive **our** rights to apply the **policy's terms and conditions** to any reimbursement or future claim. **We** cannot pre-authorize or guarantee coverage of a claim by telephone. For pre-

SAMPLE

 © 2023 Fetch Insurance Services, LLC

authorization of a **treatment**, **you** must complete a pre-authorization form, available by request or through **your** online account.

4. AGE OF YOUR PET

a. If **you** do not know the exact date of birth of **your pet**, **we** will use the average of the estimates of **your pet**'s age as referenced in **your pet**'s medical records from the veterinary clinics and shelters.

If **you** are renewing a **policy** for a dog age eight (8) years or older or a cat age ten (10) years or older, **you** must follow **your veterinarian's** advice with regards to senior wellness testing.

5. CONDITION OF YOUR PET

In order to assess a claim, **we** require complete medical records from any **veterinarian** who has treated **your pet**.

6. CARE FOR YOUR PET

a. In consideration of the premium charged, it is hereby agreed that, as a condition of this insurance, **you** must take care of **your pet** and arrange and pay for **your pet** to have the following:
   i. An annual examination by a **veterinarian**;
   ii. An annual dental exam; and
   iii. Any **treatment** normally suggested by a **veterinarian** to prevent **illness** or **injury**.

b. If **your pet** has not been examined by a **veterinarian** within six (6) months prior to the effective date of the **policy, you** must arrange to have **your pet** examined at **your** own expense within thirty (30) days of the effective date of the **policy**. Any **medical condition(s), clinical sign(s), behavioral disorder(s) or illness(es)** observed or recorded during the **first exam**, and all costs associated therewith, are automatically excluded from coverage. Additionally, any conditions that are related to, caused by, or resulting from **medical condition(s), clinical sign(s), behavioral disorder(s) or illness(es)** observed or recorded at the **first exam** performed after the effective date of the **policy** are also excluded from coverage.

c. If your pet does not receive an annual examination within each policy period following the first 12-month policy period of coverage with us, any illness, clinical sign(s) or behavioral disorder observed or recorded at the next examination will be excluded from coverage.

d. To be afforded coverage for the diseases listed below, **you** must keep **your pet** vaccinated at **your** expense, as recommended by **your veterinarian**. **We** will not reimburse **you** for any claims that result from or are related to any **illness** that is listed below that a **veterinarian** recommended vaccine would have prevented.

   Dogs:
   i. Canine distemper;
   ii. Canine adenovirus 2 (canine viral hepatitis);
   iii. Canine parainfluenza;
   iv. Canine parvovirus;
   v. Leptospirosis; or
   vi. Rabies.

   Cats:
   i. Feline viral rhinotracheitis;
   ii. Feline calicivirus;
   iii. Feline panleukopenia; or
   iv. Feline leukemia virus.

e. **You** must take **your pet** to be examined and treated by a **veterinarian** within forty-eight (48) hours after first noticing **clinical sign(s)** relating to an **illness** or **injury**.

SAMPLE

 © 2023 Fetch Insurance Services, LLC

f. In support of **your** care for **your pet**, **we** may, from time to time, offer wellness materials or programs to **you** and **your pet**.

7. CONCEALMENT, MISREPRESENTATION OR FRAUD

This **policy** and all policies held by **you** may be voided immediately in any case of fraud by **you** at any time as it relates to this **policy. Your policies** may also be voided if **you** at any time intentionally conceal, misrepresent or exaggerate a material fact concerning:

a. this or any **policy**;
b. **your pet**; or
c. a claim under this or any **policy**.

8. COOPERATION, INFORMATION AND EXAMINATION

You agree that any **veterinarian** who has treated **your pet** has **your** permission to release any information **we** may ask for about **your pet**. **You** further agree that **we** have the right to have **your pet** examined by a **veterinarian** of **our** choosing at **our** own expense. In the event of any disagreement in the diagnosis of **your pet**'s condition(s) or **treatment(s)** between **your** and **our veterinarian**, an independent **veterinarian** mutually agreed upon by both parties will be appointed. Written agreement signed by any two of these three will be binding subject to **our** mutual agreement. The costs incurred by the independent **veterinarian** are shared equally by both **you** and **us**.

9. TRANSFER OF YOUR RIGHTS AND DUTIES

You must be the owner of the **pet**. If ownership of the **pet** transfers to another individual, coverage may be continued without interruption, if approved in writing by **us** upon **our** receipt of proof of transfer of ownership and continued payment of premium.

10. CHANGING YOUR LEVEL OF COVERAGE

You may apply to decrease **your maximum annual policy coverage** or increase **your deductible** and/or **your co-pay** at any time during the **policy period.** This request must be made to **us** in writing. If **we** approve, the request will become effective on the first day of the month following approval. **You** may apply to increase the **maximum annual policy coverage** or decrease **your deductible** and/or **your co-pay** once a year at renewal, provided that **you** have not previously filed a claim with **us.** This request must be in writing and if **we** approve will become effective upon renewal following approval.

A new **declarations page** or a change endorsement indicating **your** new level of coverage will be issued on approval. Any **exclusion(s)** already on the **policy** will carry over.

VIII. OTHER TERMS AND CONDITIONS

1. LEGAL ACTIONS

No one may bring a legal action against **us** until there has been full compliance with all the terms of this **policy**. No action at law or in equity shall be brought to recover on this **policy** prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this **policy**. **You** will have three (3) years from the time written proof of loss is required to be furnished to take legal action against **us** with respect to recovery of a claim under this **policy**.

2. APPEALS

In the event of any disagreement regarding the outcome of a claim, **you** may appeal to have **your** claim undergo internal review. All requests to appeal **your** claim must be made in writing to **us** within ninety (90) days of the denial of **your** claim by **us**. Any submitted appeal should state clearly

SAMPLE

 © 2023 Fetch Insurance Services, LLC

why **you** or **your veterinarian** disagrees with the initial determination, along with any supporting documentation.

Internal Review Process:
Your claim will be reviewed by one of **our** claims specialists in collaboration with a claims manager and **our veterinarian**, when applicable. A written notice of the outcome of the internal review will be sent to **you**. If the original claims decision is upheld based on the internal review, the written notice will cite the specific reasons for the decision, citing the relevant sections of this **policy**.

3. OUR RIGHT TO RECOVER PAYMENT

a. If there is other valid coverage, not with **us**, providing coverage for the same loss and of which **we** have not been given written notice prior to the condition or commencement of loss, **we** may assert a right of contribution. **You** agree to assist **us** in **our** effort to obtain contribution.

b. This **policy** will only respond to claim amounts remaining after all other valid insurance has been exhausted, if collectable or not, subject to the terms and conditions of this **policy**. If all valid insurance is **excess insurance**, **our** share is the proportion that **our** applicable limit bears to the total applicable limits of all insurers. But **we** do not pay more than this **policy's Maximum Annual Policy Coverage**. It is **your** responsibility to notify **us** if other insurance is in effect. Failure to do so will be deemed concealment or misrepresentation and may void coverage (see also Section VII.7).

4. ENTIRE POLICY

This **policy** contains all the agreements between **you** and **us**. The terms of this **policy** may not be changed or waived except by an endorsement issued by **us** and made a part of this **policy**.

5. CONFORMITY TO STATE STATUTES

When this **policy's** provisions are in conflict with the statutes of the state in which this **policy** is issued, the provisions are amended to conform to such statutes.

6. CANCELLATION AND NONRENEWAL

a. **You** may cancel this **policy** at any time by calling **us** toll-free at 1-866-467-3875 or by mailing or delivering to **us** advance written notice of cancellation at info@fetchpet.com or to Fetch Pet Insurance, PO Box 1489, Bolingbrook, IL 60440. If **you** notify **us** within the first thirty (30) days from the effective date shown on the **declarations page**, and **you** have not submitted any claim against this **policy**, **we** will refund the entire premium. After thirty (30) days, **we** will return the pro rata premium based upon the date of termination of this **policy**.

b. **We** may cancel this **policy** (or any renewal of this **policy**) if **you** fail to pay the premium when due. In such a case, a written notice will be sent to **you** at **your** address shown on the **declarations page**, providing at least fifteen (15) days' notice of **our** intent to cancel. Otherwise, **we** may cancel this **policy** by providing **you** at least thirty (30) days' written notice.

c. **We** may cancel the **policy** due to the following**:**
   i. **Your** material failure to comply with **policy terms and conditions**.
   ii. **You** fail to send **us** relevant information in respect to a claim; or
   iii. **You** materially misrepresent or exaggerate relevant information pertaining to this **policy** or a claim.

d. **We** may elect not to renew this **policy** on the expiration date (for any of the reasons stated in Section VIII.6.c above). In addition, **we** may elect not to renew this **policy** on the expiration date due to a material change in the condition, factor, or loss experience material to insurability. **We** may do so by writing to **you** at **your** last known address shown on the **declarations page**, with a written notice at least sixty (60) days prior to the expiration date.

SAMPLE

 © 2023 Fetch Insurance Services, LLC

Table of Contents

SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, PLEASE READ ALL THE POLICY PROVISIONS CAREFULLY.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the Conditions of Coverage and Description of Benefits sections for full details.

Eligible Persons: An Eligible Person is an individual who meets all of the requirements of one of the covered classes shown below:

Class A	**Principal Sum**
All Active Members of the Policyholder	$40,000
Class B	
All Active Members of the Policyholder	$80,000

CONDITIONS OF COVERAGE
The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages:

Class A

24-HOUR BUSINESS AND PLEASURE COVERAGE

Class B

LINE OF DUTY OCCUPATIONAL COVERAGE

Additional Participating Organizations (if applicable)

BENEFITS

Aggregate Limit of Indemnity

Applies to:	**Benefit Amount**
Accidental Death and Dismemberment, Coma, Paralysis	Ten times the Class A Principal Sum, not to exceed $1,000,000.

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses, Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident that occurs under one of the Conditions of Coverage, as specified above. This Aggregate Limit of Indemnity is payable only once, should more than one Condition of Coverage apply, We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Loss must occur within (Loss period does not apply to Loss of Life)	365 days of the Covered Accident

Covered Loss	**Benefit Amount**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Use of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of Speech and Hearing (in Both Ears)	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Use of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in Both Ears)	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all Toes of the Same Foot	25% of the Principal Sum
Loss of Thumb	25% of the Principal Sum
Loss of Index Finger	25% of the Principal Sum
Loss of any Joint on Either Hand	6.25% of the Principal Sum
Loss of 2nd, 3rd, or 4th Finger on Either Hand	12.5% of the Principal Sum
Loss of Large Toe of Either Foot	5% of the Principal Sum
Loss of a Joint of a Toe	1% of the Principal Sum

Exposure and Disappearance Benefit	**Included**

ACCIDENTAL SEVERE BURN AND DISFIGUREMENT BENEFIT

Benefit Amount	
75%-100% Body Disfigurement	100% of the Principal Sum subject to a Maximum Benefit of $100,000
50%-74% Body Disfigurement	75% of the Principal Sum subject to a Maximum Benefit of $100,000
25%-49% Body Disfigurement	50% of the Principal Sum subject to a Maximum Benefit of $100,000
10%-24% Body Disfigurement	25% of the Principal Sum subject to a Maximum Benefit of $100,000
Burn Classification	Third Degree

BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

Counseling must occur within	30 days of the Loss of Life or Covered Loss.
Benefit Amount	$100 per session
Maximum Number of Sessions	10
Maximum Benefit per Covered Loss	$1,000

BURIAL AND CREMATION BENEFIT

Benefit Amount	$5,000

COMA BENEFIT

Coma must occur within	30 days of the Covered Accident
Benefit Amount	1% of the Principal Sum for the first 11 months, 100% in the 12th Month.

FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT

Covered Loss must occur within	365 days of the Covered Accident
Benefit Amount	10% multiplied by the portion of the Benefit Amount applicable to a Covered Loss for Accidental Death and Dismemberment, Coma, Paralysis, as shown in the Schedule of Benefits subject to a maximum of $10,000.

HEPATITIS OCCUPATIONAL OR ASSIGNED DUTIES ACCIDENT BENEFIT

Benefit Amount	50% of the Principal Sum subject to a maximum of $50,000

HOME ALTERATION AND VEHICLE MODIFICATION EXPENSE BENEFIT

Benefit Amount	10% multiplied by the portion of the Benefit Amount applicable to a Covered Loss for Accidental Death and Dismemberment, Coma, Paralysis, as shown in the Schedule of Benefits subject to a maximum of $10,000.

MEDICAL EVACUATION BENEFIT

Benefit Amount	100% of Usual & Customary Charges
Includes Traveling Companion	
Includes Emergency Sickness	

PARALYSIS BENEFIT

Paralysis must occur within	365 days of the Covered Accident
Benefit Amount	
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum

PROSTHESIS APPLIANCE BENEFIT

Covered Loss must occur within	365 days of the Covered Accident
Benefit Amount	$1,000 per Covered Loss

REHABILITATION BENEFIT

Covered Treatment must occur within	365 days of the Covered Accident
Benefit Amount	10% multiplied by the portion of the Benefit Amount applicable to a Covered Loss for Accidental Death and Dismemberment, Coma, Paralysis, as shown in the Schedule of Benefits subject to a maximum of $10,000.

REPATRIATION BENEFIT

Benefit Amount	100% of Usual & Customary Expenses
Includes Emergency Sickness	

If an Insured Person suffers a **[**Covered Injury Death**][**or**][**Covered Illness Death**]** and a death benefit is payable under this Policy, the Company will pay expenses incurred by each Dependent Child for tuition, fees, books, room and board, transportation and any other costs payable directly to a school, or approved and certified by the school, up to the **[**Maximum Benefit Amount**][**Maximum Annual Benefit Amount**]**shown on the *Policy Schedule of Benefits***.**

[In order to qualify for benefits, a qualifying Dependent Child must:

1. be a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the Insured Person's death [or begin studies as a full-time student at an accredited school of higher learning within [1-2] year of the Insured Person's death and before reaching the limiting age shown in the Dependent Child definition]; and
2. continue His education as a full-time student in such accredited school of higher learning.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian if the child is a minor, at the end of each year **[**up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits**]***. The Company must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a benefit is payable will begin on the first of the month following the date the Insured Person died, if the surviving Dependent Child was a full-time student on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he or she begins studies in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.**]**[16]

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit Amount	25% multiplied by the Principal Sum applicable to the Covered Loss subject to a maximum of $50,000
Airbag Benefit Amount	10% multiplied by the Principal Sum applicable to the Covered Loss subject to a maximum of $25,000
Default Benefit Amount	$1,000

PREMIUM RATE TABLE

It is hereby agreed and understood that the premium amounts, and the manner in which premiums are due and payable, are as follows:

Annual $1,981

Premium Due Date – Policy Effective Date

The initial premium rate guarantee and any premium rate guarantee applicable to renewal are subject to the Cancellation and Premium Rate Change sections of the Administrative Provisions of this Policy.

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Accident or Accidental	means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.
Aircraft	means a vehicle which: 1. has a valid Airworthiness Certificate; and 2. is being flown by a pilot with a valid license to operate the Aircraft.
Airworthiness Certificate	means a “Standard" Airworthiness Certificate issued by the Federal Aviation Agency of the United States of America or its equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.
Calendar Year	means January 1st through December 31st of any year.
Common Carrier or Public Conveyance	means: 1. a Conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or 2. a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.
Conveyance	means a motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority.
Covered Accident	means an Accident that results in a Covered Loss during the Policy Term.
Covered Activity or Covered Activities	means any activity that is shown in the *Schedule of Benefits* and takes place under one of the Conditions of Coverage specified in the *Schedule of Benefits.*
Covered Expenses	means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.
Covered Injury	means Accidental bodily injury: (1) which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force; (2) which results directly and independently from all other causes from a Covered Accident; and (3) which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.
Covered Loss	means a loss which meets the requisites of one or more benefits, and results from a Covered Accident, Covered Injury or Covered Activity.
Eligible Person	means an individual as defined in the *Schedule of Benefits.*

He, His, Him refers to any individual, male or female.

Hospital means an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics; or
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Insured Person incurs an expense

Hospital Confined, Hospital Stay or Confined to a Hospital means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least 30 days.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Inpatient means confined overnight as a registered bed patient in a Hospital or other medical facility where at least one day's room and board is charged. The confinement must be on the advice of a Physician.

Insured Person means an Eligible Person, as defined in the *Schedule of Benefits*, for whom required premium has been paid when due and for whom coverage under this Policy remains in force.

Medically Necessary means medical services that: (1) are essential for diagnosis, treatment or care of the Covered Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) are ordered by a Physician and performed under His care, supervision or order.

Nurse means a licensed graduate Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) who is not:

1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household; or
4. a person employed or retained by the Policyholder.

Paralysis/Paralyzed	means Quadriplegia, Paraplegia, Hemiplegia or Uniplegia that is expected to last for a continuous period of 12 months or more from the earlier of the date of the Covered Accident causing paralysis or the date of the diagnosis. "Quadriplegia" means the complete and irreversible paralysis of both upper and lower limbs. "Paraplegia" means the complete and irreversible paralysis of both lower limbs or both upper limbs. "Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body. "Uniplegia" means the complete and irreversible paralysis of one limb. "Limb" means entire arm or entire leg.
Physician	means a licensed health care provider practicing within the scope of his license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not: 1 the Insured Person; 2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse; 3. a person living in the Insured Person's household; 4. a person employed or retained by the Policyholder; or 5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.
Policyholder	means the entity, named on this Policy's face page, to which the Company issues this Policy.
Policy Term	means the time period defined for the Policyholder shown on this Policy's face page.
Private Passenger Automobile	means a validly registered, four wheel private passenger car, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxi cab, bus or other Public Conveyance will not be considered a Private Passenger Automobile.
Scheduled Airlines or Aircraft	means any carrier holding a certificate, license or similar authorization for civilian scheduled air transport issued by the country of the Aircraft's registry, and which, in accordance with that authorization flies, maintains and publishes schedules and tariffs for regular passenger service between named cities at regular and specified times, but only if the Aircraft is then used for any regular or chartered flight operated by such carrier.
Spouse	means the Insured Person's lawful spouse.
Traveling Companion	means an individual or individuals who have made advance arrangement with the Insured Person to travel together.
Usual and Customary Charge	means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.
We, Us, Our	means AXIS Insurance Company.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligibility

A person is eligible for insurance under this Policy when He meets the definition of Eligible Person shown in the *Schedule of Benefits.* An Eligible Person may be insured under only one covered class, even though He may be eligible under more than one covered class.

Policy Effective Date

The Company agrees to provide Accident insurance benefits described in this Policy in consideration of the Policyholder's application and payment of the Premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page.

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Insured Person resulting from a change in benefits provided by this Policy or a change in the Insured Person's covered class will take effect on the date of such changes.

Termination of Insurance

Insurance for the Insured Person will end on the earliest of:

1. the date the person is no longer in an Eligible Class;
2. the end of the period for which the last premium is made;
3. the date this Policy ends;

Termination does not affect a claim for a Covered Loss due to a Covered Accident or Emergency Sickness that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable benefit limit or maximums, as shown in the *Schedule of Benefits*, have been paid.

COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface,, except as:
   a. a fare-paying passenger on a regularly scheduled commercial or charter airline;
   b. a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight;
   c. a passenger in a Military Aircraft flown by the air mobility Command or its foreign equivalent;
6. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury;
9. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
10. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;

In addition, benefits will not be paid for services or treatment rendered by any person who is:

   a. employed or retained by the Policyholder;
   b. living in the Insured Person's household;
   c. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse; or
   d. the Insured Person.

CLAIM PROVISIONS

Beneficiary

If more than one person is named as beneficiary, the interests of each will be equal unless the Insured Person has specified otherwise. The share of any beneficiary who does not survive the Insured Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Insured Person dies while benefits are payable to Him, the Company may make direct payment to the first surviving class of the following classes of persons:

1. Spouse;
2. child or children;
3. parents;
4. siblings; or
5. estate of the Insured Person.

Claim Forms

The Company or its designated authorized agent will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the Company received notice of claim, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made. The notice should include the Insured Person’s name, the Policyholder's name and the Policy Number. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

Notice of Claim

Written notice of claim must be given to the Company or its designated authorized agent within 30 days after the occurrence or commencement of the Insured Person's Covered Loss or Emergency Sickness, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company or its designated authorized agent, with information sufficient to identify the Insured Person, is deemed notice to the Company. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form.

Payment of Claims

All benefits will be paid in United States currency. Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person’s beneficiary as described in the Beneficiary Provision and these Claim Provisions.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments due have been made, the amount still payable will be paid to His beneficiary as described in the Beneficiary Provision.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to a parent, guardian, or other person actually supporting Him. If the payee has no legal guardian for His property, a payment not exceeding $1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges liability to the extent of the payment made.

Time of Payment of Claims

Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Conditional Claim Payment

If the Insured Person incurs expenses for Covered Injuries received in a Covered Loss and in Our opinion a third party may be liable, the Company will pay benefits if:
the Insured Person first agrees in writing to refund the lesser of:

i) the amount the Company actually paid for such expenses; and
ii) the amount actually received from the third party regardless of whether the amount is for such expenses; and the third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, if the third party's liability is satisfied in an amount less than the benefits paid under this Policy, the Company will pay the difference.

Legal Actions

No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought after expiry of the applicable statute of limitations from the time proof of loss is required to be furnished under this Policy.

Physical Examination And Autopsy

The Company, at its own expense, has the right and opportunity to examine the Insured Person when and as often as the Company may reasonably require while a claim is pending and to make an autopsy in case of death, where it is not prohibited by law.

Proof of Loss

Written proof of loss must be furnished to the Company within 90 days after the date of the Covered Loss or Emergency Sickness. In the case of a claim for loss of time for disability, written proof of such loss must be furnished to the Company within 90 days after the commencement of the period for which the Company is liable. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as may reasonably be required. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to furnish proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

Subrogation

The Company has the right to recover all payments including future payments, which the Company has made, or will be obligated to pay in the future, to the Insured Person from anyone liable for the Covered Loss. If the Insured Person recovers from anyone liable for the Covered Loss, the Company will be reimbursed first from such recovery to the extent of the Company's payments to the Insured Person. The Insured Person agrees to assist the Company in preserving It's rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by the Company.

ADMINISTRATIVE PROVISIONS

Cancellation

The Company or the Policyholder may cancel this Policy after the first year or Policy Term or as of any Premium Due Date, by giving the other party 31 days advance written or authorized electronic notice. Any premium rate guarantee will not affect the Company's or the Policyholder's right to cancel this Policy.

If a premium is not paid when due, the Company will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the Premium Rate Table.

Cancellation does not affect a claim for a Covered Loss when the Covered Accident or Emergency Sickness occurs before the cancellation date.

Grace Period

A grace period of 31 days will be provided for the payment of any premium due after the first Premium Due Date. During the grace period, the Policy shall continue in force, unless the Policyholder has given written notice of discontinuance in advance of the Premium Due Date and in accordance with the terms of this Policy. If the required premium is not paid during the grace period, coverage will terminate on the last day of the grace period. The Policyholder will be liable for the payment of a pro rata premium for the time the Policy was in force during the grace period.

Premiums

Premium rates are expressed in, and premiums are payable in, United States currency. The Company will provide notifications of premiums due or premium changes, to the most current address in Our files, to the Policyholder.

Premium Payment

The total premium paid by the Policyholder is the sum of premiums for all Insured Persons. The initial premium is due on the Policy Effective Date and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the Premium Rate Table, unless the Policyholder and the Company agree to another mode of premium payment. Premiums are paid at the Company's Home Office or to the Company's authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premium, except as provided in any applicable Grace Period section.

Premium Rate Changes

The Company may change premium rates at the end of any Policy Term or any premium rate guarantee period with at least 31 days advance notice to the last known address of the Policyholder. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

The Company may change the premium rate during a Policy Term or during any applicable premium rate guarantee period if any of the following occurs:

1. the terms of the Policy change;
2. coverage is reinstated following failure to pay premium during the Grace Period; or
3. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under the Policy.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit

The Company will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

Reinstatement

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are a written application of the Policyholder satisfactory to the Company and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

GENERAL PROVISIONS

Addition of New Insured Persons

All Insured Persons added to the Classes of Eligible Persons in the *Schedule of Benefits* are eligible for insurance under this Policy.

Assignment

The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if the Company receives it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident or Emergency Sickness. Any other attempt to assign will be void.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

Certificates

Where required by law, the Company will provide a certificate of insurance for delivery to the Insured Person. Each certificate will set forth a statement as to the insurance coverage to which the Insured Person is entitled, and to whom the insurance benefits are payable, and a statement as to any family member, Spouse or dependent's coverage. If family members or dependents are included in the coverage, the insurer need only issue one certificate to each family unit.

Clerical Error

A person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, the Company will adjust the premium fairly.

Conformity with Statutes

Any provision in this Policy that is in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Entire Contract; Changes

The Policy and any attached papers make up the entire contract between the Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any Insured Person will be considered representations and not warranties. No written statement made by an Insured Person will be used in any contest unless a copy of the statement is furnished to the Insured Person or, in the event of the death or incapacity of the Insured Person, to His beneficiary or personal representative.

No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Examination of the Policy

This Policy will be available for inspection at the Policyholder's office during regular business hours.

Incontestability

The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, misrepresentation or fraud.

However, the Company may contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

Misstatement of Fact

If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Noncompliance with Policy Requirements

Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.

Policy Changes

No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. The Company may agree with the Policyholder to modify a plan of benefits without the Insured Person's consent.

Records

The Policyholder or its authorized Administrator will maintain the records of the Insured Person's insurance under this Policy. The Company will be permitted to examine the Policyholder's records relating to the insurance under this Policy at any reasonable time. The Policyholder is acting as an agent of the Insured Person for transactions relating to this insurance. The actions of the Policyholder will not be considered the actions of the Company.

Reporting Requirements

The Policyholder or its authorized agent must report all of the following to the Company by the Premium Due Date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated; and
4. additional information required by the Company.

The Company may, at the Company's sole discretion, waive reporting of any information specified above.

Workers' Compensation

This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

CONDITIONS OF COVERAGE

This Section describes the Conditions of Coverage under which benefits provided by this Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the Common Exclusions sections in order to understand all of the terms, conditions and limitations of coverage.

24-HOUR BUSINESS AND PLEASURE COVERAGE

The Company will pay the Benefit Amount shown in the Schedule of Benefits, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs any time while insured by this Policy including riding in or entering an Aircraft.

Exclusions

Exclusions that apply to this Condition of Coverage are in the Common Exclusions Section.

LINE OF DUTY OCCUPATIONAL COVERAGE

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss that occurs during a Covered Activity and while the Insured Person is Acting in the Line of Duty.

The Covered Loss must take place while:
1. the Insured Person is on duty, on or off the Policyholder's premises; or
2. Acting in the Line of Duty during response to an emergency while off duty.

Definitions

For purposes of this Condition of Coverage:

Acting in the Line of Duty means acts done according to the standards set by Policyholder for the type of work in which the Insured Person is engaged.

Exclusions

Exclusions that apply to this Condition of Coverage are in the *Common Exclusions* Section.

DESCRIPTION OF BENEFITS

This Description of Benefits Section describes the Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits.* Please read these and the Common Exclusions section in order to understand all of the terms, conditions and limitations applicable to these Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Losses

The Company will pay the Benefit Amount for any one of the Covered Losses listed in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if the Insured Person suffers a loss as a result of a Covered Injury within the applicable time period specified in the *Schedule of Benefits.*

If the Insured Person sustains more than one Covered Loss as a result of the same Covered Accident, the Company will pay the Benefit Amount for the Covered Loss for which the largest benefit is payable.

Exposure and Disappearance

If by reason of an Accident occurring while an Insured Person's coverage is in force under this Policy, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a Covered Loss for which an Accidental Death or Accidental Dismemberment Benefit is otherwise payable under the Policy, the Covered Loss will be covered under the terms of this Policy.

If the body of an Insured Person has not been found, within one year of the disappearance, forced landing, stranding, sinking or wrecking of a Conveyance in which the Insured Person was an occupant while covered under this Policy, then it will be deemed, subject to all other terms and provisions of this Policy, that the Insured Person has suffered an Accidental Death that would have been payable under the Policy.

Definitions

For purposes of this Benefit:

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Use of a Hand or Foot means total loss of all ability to move the hand or foot, within 365 days of a Covered Accident, that continues for 6 months and is expected to continue for the remainder of the Insured Person's lifetime.

Loss of Sight means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Severance means complete separation and dismemberment of the part from the body.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

ACCIDENTAL SEVERE BURN AND DISFIGUREMENT BENEFIT

The Company will pay the Benefit Amount, shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Severe Burn due to a Covered Accident.

A Physician must determine that the burn satisfies all of the following:
1. involves the minimum percentage shown in the *Schedule of Benefits*;
2. be classified as shown in the *Schedule of Benefits*; and
3. results in disfigurement or loss of physical abilities.

Definitions

For purposes of this Benefit:

Severe Burn/Severely Burned means cosmetic disfigurement of at least 10% of the surface of a body area due to a Covered Injury that is a third-degree burn, as determined by a Physician. The Company has the right, at its own expense, to have the Physician's determination verified by a Physician of the Company's choice. A third degree, full-thickness burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits* for counseling sessions, subject to all applicable conditions and exclusions, when the Insured Person requires bereavement and trauma counseling because of an Accidental Death or Covered Loss under this Policy. Such counseling must meet all of the following conditions:
1. covered bereavement and trauma counseling expenses must be incurred within the time period shown on the *Schedule of Benefits* from the date of the Covered Accident causing another Insured Person's death;
2. the expense is charged for a bereavement or trauma counseling session for the Insured Person;
3. counseling is provided under the care, supervision or order of a Physician; and
4. a charge would have been made if no insurance existed.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

BURIAL AND CREMATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, for burial or cremation of the Insured Person who dies from a Covered Injury and an Accidental Death Benefit is payable under this Policy.

Exclusions Exclusions that apply to this Benefit are in the Common Exclusions Section.

COMA BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person suffers a Covered Injury that results in Coma, within the applicable time period specified in the *Schedule of Benefits.*

Definitions For purposes of this Benefit:

Coma means a profound state of unconsciousness from which the Insured Person is not likely to be aroused through powerful stimulation. The Coma must begin within 30 days of the Covered Accident, continue for 30 consecutive days and must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Accident.

Exclusions Exclusions that apply to this Benefit are in the Common Exclusions Section.

FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss that occurs during a Felonious Assault or Violent Crime as described below. A police report detailing the Felonious Assault or Violent Crime must be provided before any benefits will be paid.

Definitions For purposes of this Benefit:

Felonious Assault means any willful and unlawful use of force by an individual against the Insured Person in connection with the commission, or attempted commission of robbery, theft, kidnapping, hostage taking, hijacking, assault, murder, manslaughter, riot, or insurrection. Such use of force must be a felony or equivalent of a felony under any country, state, territory or local statutory or common law applicable in the jurisdiction where the Covered Loss occurs.

Fellow Employee means a person employed by the same Employer as the Insured Person or by a Policyholder that is an affiliated or subsidiary corporation. It shall also include any person who was so employed, but whose employment was terminated not more than 45 days prior to the date on which the defined Felonious Assault or Violent Crime was committed.

Violent Crime means violent crime that involves force or threat of force and is composed of four offenses: murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault.

Exclusions

Benefits will not be paid for a Covered Loss incurred during any:
1. Felonious Assault or Violent Crime committed by the Insured Person; or
2. Felonious Assault or Violent Crime committed upon the Insured Person by a Fellow Employee.

Other exclusions that apply to this Benefit are in the Common Exclusions Section.

HEPATITIS OCCUPATIONAL OR ASSIGNED DUTIES ACCIDENT BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Injury during the performance of Occupational or Assigned Duties and it results in the Insured Person acquiring and testing positive for Hepatitis C within one year of the date of an Occupational or Assigned Duties Covered Accident.

The benefit is payable if, within 96 hours of the Covered Accident, the Insured Person: 1) reports the Covered Accident to the Company and the Policyholder in writing; and 2) undergoes a Food and Drug Administration (FDA) approved preliminary screening test for Hepatitis which indicates negativity with respect to the presence of any antibodies or antigens to such disease. The Company must receive written notification of the test results, from the laboratory that performed the test, as soon as reasonably possible.

The Company will not pay for any expenses incurred for testing.

Definitions

For purposes of this Benefit:

Occupational Duties means the performance of duties that are:
1. normally performed on behalf of the Policyholder; and
2. assisting, caring for or otherwise involved with, sick or injured persons.

Assigned Duties means performance of duties, whether for pay or on a volunteer basis, that are:
1. assigned by the Policyholder; and
2. assisting, caring for or otherwise involved with, sick or injured persons.

Hepatitis means viral Hepatitis C and does not include Hepatitis A,B, E or D.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss and when all of the following conditions are met:
1. before the date of the Covered Accident, the Insured Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. as a direct result of such Covered Accident, the Insured Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle; and
3. the Insured Person requires home alteration or vehicle modification within one year of the date of the Covered Loss.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

MEDICAL EVACUATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person or Traveling Companion suffers a Covered Injury or an Emergency Sickness that warrants His Emergency Evacuation while He is outside a 100 mile radius from His current place of primary residence. The Company will pay for Covered Emergency Evacuation Expenses reasonably incurred for all Emergency Evacuations from the same Covered Accident or all Emergency Sicknesses from the same or related causes.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured Person's or Traveling Companion's Covered Injury or an Emergency Sickness warrants His Emergency Evacuation. All transportation arrangements made for the Emergency Evacuation must be by the most direct and economical Conveyance and route possible. **AXIS's travel assistance service provider** must make all arrangements and must authorize all expenses in advance for this Benefit to be payable. However, the Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact **AXIS's travel assistance service provider** in advance.

Definitions

For purposes of this Benefit:

Covered Emergency Evacuation Expense(s) means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed; or (4) Usual and Customary Charges.

Emergency Evacuation means, if warranted by the severity of the Insured Person's or Traveling Companion's Covered Injury or Emergency Sickness : (1) the Insured Person's or Traveling Companion's immediate transportation from the place where He suffers a Covered Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Insured Person's or Traveling Companion's transportation to His current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering a Covered Injury or Emergency Sickness and being treated at a local Hospital or other medical facility; or (3) both (1) and (2) above. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such transportation.

Emergency Sickness means an illness or disease diagnosed by a Physician which:

1. causes a severe or acute symptom that, if not provided with immediate treatment, would reasonably be expected to result in serious deterioration of the Insured Person's health or place His life in jeopardy; and
2. first manifests itself suddenly and unexpectedly while the Insured Person is covered under this Policy and is participating in a Covered Activity.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

PARALYSIS BENEFIT

The Company will pay the Benefit Amount shown on the *Schedule of Benefits* for that type of Paralysis, subject to all conditions and exclusions, if an Insured Person suffers Paralysis as a result of a Covered Injury. If the Insured Person suffers more than one type of Paralysis as a result of the same Covered Accident, only one amount, the largest, will be paid.

Definitions

For the purposes of this Benefit:

Paralysis/Paralyzed means Quadriplegia, Paraplegia, Hemiplegia or Uniplegia that is expected to last for a continuous period of 12 months or more from the earlier of the date of the Covered Accident causing paralysis or the date of the diagnosis. “Quadriplegia” means the complete and irreversible paralysis of both upper and lower limbs. “Paraplegia” means the complete and irreversible paralysis of both lower limbs or both upper limbs. “Hemiplegia” means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body. “Uniplegia” means the complete and irreversible paralysis of one limb. “Limb” means entire arm or entire leg.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

PROSTHESIS APPLIANCE BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person suffers a Covered Loss that requires use of a Prosthetic Appliance Device. The Company will pay the Prosthesis Appliance Benefit when a charge is incurred. This Benefit is not payable for hearing aids, wigs, or any dental aids, including false teeth.

Definitions

For purposes of this Benefit:

Prosthetic Appliance Device means a removable artificial substitute or replacement of a part of the body. It does not include:

- dental aids, including false teeth, treatment or repair of caps, crowns, braces, bridges, dentures, fillings or other artificial dental devices;
- eyeglasses;
- cosmetic prosthesis such as hair wigs;
- other types of prosthesis devices that are permanently implanted such as artificial hip or tooth;
- any experimental prosthesis; or
  any auditory prosthesis (a device that substitutes for or enhances ability to hear).

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

REHABILITATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, when the Insured Person requires Rehabilitation after sustaining a Covered Loss. The Insured Person must require Rehabilitation within 365 days of the Covered Loss.

Definitions

For purposes of this Benefit:

Rehabilitation means medical services, supplies, treatment, Hospital Confinement or part of a Hospital Confinement that satisfies all of the following conditions:

1. is essential for physical rehabilitation required due to the Insured Person's Covered Loss or Injury;
2. meets generally accepted standards of medical practice;
3. is performed under the care, supervision or order of a Physician; and
4. prepares the Insured Person to return to His or any other occupation.

Exclusions Exclusions that apply to this Benefit are in the Common Exclusions Section.

REPATRIATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person suffers Loss of Life due to a Covered Injury or an Emergency Sickness while outside a 100 mile radius from His current place of primary residence. The Company will pay for Covered Expenses reasonably incurred to return His body to His current place of primary residence.

Covered Expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical Conveyance and route possible; or (4) Usual and Customary Charges.

AXIS's travel assistance service provider must make all arrangements and must authorize all expenses in advance for this Benefit to be payable. However, the Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact **AXIS's travel assistance service provider** in advance

Definitions For purposes of this Benefit:

Emergency Sickness means an illness or disease diagnosed by a Physician which:
1. causes a severe or acute symptom that, if not provided with immediate treatment, would reasonably be expected to result in serious deterioration of the Insured Person's health or place His life in jeopardy; and
2. first manifests itself suddenly and unexpectedly while the Insured Person is covered under this Policy and is participating in a Covered Activity.

Exclusions Exclusions that apply to this Benefit are in the Common Exclusions Section.

SEATBELT AND AIRBAG BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, when the Insured Person's death results from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in a Private Passenger Automobile. An additional benefit is provided if the Insured Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Insured Person's claim to the Company.

If such certification or police report is not available or it is unclear whether the Insured Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, the Company will pay a Default Benefit Amount shown in the *Schedule of Benefits* to the Insured Person's beneficiary.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.

Definitions

For purposes of this Benefit:

Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas or a child safety device.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

NOTICE REGARDING NONDISCRIMINATION

AXIS Insurance Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. AXIS Insurance Company will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. AXIS Insurance Company will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

SUMMARY OF THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING LIMITATIONS AND EXCLUSIONS

INTRODUCTION

Residents of Pennsylvania who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable. Insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.

This Information is Provided By:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, Pennsylvania 19087
(610) 975-0572

SUMMARY

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of the law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the Pennsylvania Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Pennsylvania, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Pennsylvania at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation (e.g., a blue cross or blue shield plan), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, association or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields that exceed an average rate;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificated or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the overall $300,000 limit, the Association will pay up to $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender or withdrawal values. For annuities, the Association will pay up to $300,000 in annuity benefits, or $100,000 in net cash surrender or withdrawal benefits. For health insurance, the Association will pay up to $300,000, including any net cash surrender or withdrawal benefits.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AXIS Insurance Company values its relationship with you. Protecting the privacy of the information we have about you is of great importance to us. We want you to understand how we protect the confidentially of information as well as how and why we use and disclose it. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to this information. "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare.

This privacy policy applies to policies underwritten by AXIS Insurance Company. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice. We reserve the right to change the terms of this notice, and should that occur, we will provide you with a copy of the new notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose your Protected Health Information (PHI) for the purposes of your treatment, for payment and for health care operations. Not every use or disclosure in a category is listed. However all of the ways that we may use or disclose PHI will fall within one of these categories.

Your Authorization: Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing use or disclosure. You may take away this authorization at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

For Payment: We use and disclose PHI as necessary for payment purposes. For example, we may use your PHI to process a claim or may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and disclose PHI for our health care operations such as customer service, premium rating, fraud and abuse prevention and detection, and other functions related to your health policy. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To Others: You may authorize us in writing to give your PHI to someone else for any reason. Also, if you are present, and provide authorization, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are unavailable, incapacitated, or facing an emergency medical situation, we may share limited PHI with a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also use or disclose your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared for any purpose as required by law.

We may share PHI with the sponsor of the plan or use in the administration of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

YOUR HIPAA PRIVACY RIGHTS

Access to Your PHI

You have the right to obtain a copy and inspect specific items of your PHI, such as your policy or claim information, for as long as we maintain it. We may deny your request to access certain PHI, as permitted or required by law. We may require your request for access in writing. Your request for access should contain as much detail as possible regarding the PHI you wish to review. We may charge a reasonable fee for access to your PHI.

Amendments to Your PHI

You have the right to request that the PHI we maintain about you be amended or corrected if you believe it is incorrect. We are not legally obligated to make all requested amendments but will give each request appropriate consideration. Requests for amendment must be in writing and must state the reasons for the amendment request.

Accounting for Disclosures of Your PHI

You have the right to request an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. Requests must be made in writing. We are not legally obligated to provide an accounting of every disclosure but will give each request appropriate consideration. The accounting will not include disclosures made prior to June 1, 2011.

Restrictions on Uses and Disclosures of Your PHI

You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. We are not legally required to agree to your restriction request but will give each request appropriate consideration.

Confidential Communication of PHI

You have the right to request to receive communications from us regarding your PHI by another method of contact or at an alternative address. We will accommodate reasonable requests, which must clearly state that disclosure of all or part of the information could endanger your health or safety.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services in Washington, D.C. We will not take action against you for filing a complaint.

Contact Information

If you have questions or need further assistance regarding this Notice, or wish to exercise any of the abovementioned rights, you may write to us at

Administrative Address:
AXIS Insurance Company
1 University Square Drive, Suite 200
Princeton, NJ 08540
888.870.AXIS (2947)
General questions - please send to USSales.AccHealth@axiscapital.com

Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective June 1, 2011

TABLE OF CONTENTS

POLICY SCHEDULE

Policyholder:	**Anytown USA Fire Protection District**		
Policy Number:	**PRCO-XXXXX-XXXXXXX**	**Effective Date:**	**03/01/2023**
Renewal Date:	**03/01/2026**	**Expiration Date:**	**02/28/2026**
Payment Method:	3 Year Annual Installment	**Total Premium:**	**$32,442**
Annual Anniversary Date:	March 1	**Policy Term:**	**03/01/2023 - 02/28/2026**

Rate Guarantee Period: 3 Years

The initial premium rate guarantee and any premium rate guarantee applicable to renewal are subject to the Policy Term and Renewal and Premium Rate Change sections of this Policy.

Premium Due Dates: Premium is due and payable in annual installments with the first installment due as of the Policy Effective Date and subsequent installments due as of each Anniversary Date	**1st Installment:**	03/01/2023	$10,814
	2nd Installment:	03/01/2024	$10,814
	3rd Installment:	03/01/2025	$10,814

Eligible Persons:		
Class I	All volunteer classes of membership including but not limited to a Volunteer Member, Emergency Volunteer, Auxiliary Member, Fire Corps, Community Volunteer, Board Member, Trustee, Administrative Personnel, Junior Member, Member in Training, Probationary Member, and Part-Time Employees of the Policyholder.	Effective Date: 03/01/2023
Class II	Career Personnel of the Policyholder.	Effective Date: 03/01/2023

POLICY SCHEDULE OF BENEFITS
SUMMARY OF COVERAGE

This Policy provides coverage for the following benefits that indicate that they are "Included" or that provide a specified amount opposite the name of the benefit. Benefits indicated as "Not Included" are not provided under this Policy.

SECTION I: DEATH BENEFITS

	Class I	Class II
I.A. COVERED INJURY DEATH BENEFIT		
Principal Sum	$50,000	$50,000
I.B. COVERED ILLNESS DEATH BENEFIT		
Principal Sum	$50,000	$50,000
I.C. HIV POSITIVE DIAGNOSIS LUMP SUM BENEFIT		
Benefit Amount	$50,000	$50,000
I.D. BEREAVEMENT BENEFIT		
Maximum Benefit Amount	$5,000	$5,000
I.E. DEPENDENT CHILD BENEFIT		
Benefit Amount (for each Dependent Child)	$10,000	$10,000
I.F. SEATBELT AND AIRBAG BENEFIT		
Seatbelt Benefit Amount	$12,500	$12,500
Airbag Benefit Amount	$12,500	$12,500
I.G. FINAL EXPENSES BENEFIT		
Maximum Benefit Amount *(includes repatriation to the funeral home as well as other locations, cremation, burial services, grave marker/headstone)*	$5,000	$5,000
I.H. SPOUSAL BENEFIT		
Benefit Amount	$15,000	$15,000
I.I. SURVIVING SPOUSE EDUCATION BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
Maximum Benefit Period	4 years	4 years
I.J. DEPENDENT CHILD EDUCATION BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
Maximum Benefit Period	4 years	4 years

SECTION II: IMPAIRMENT BENEFITS

	Class I	Class II
II.A. DISMEMBERMENT, LOSS OF SPEECH OR HEARING BENEFIT		
Impairment Principal Sum	$50,000	$50,000
II.B. VISION IMPAIRMENT BENEFIT		
Vision Impairment Principal Sum	$50,000	$50,000
II.C. COSMETIC DISFIGUREMENT FROM BURNS BENEFIT		
Cosmetic Disfigurement from Burns Principal Sum	$50,000	$50,000
II.D. PERMANENT PHYSICAL IMPAIRMENT BENEFIT		
Permanent Physical Impairment Principal Sum	$50,000	$50,000
II.E. FELONIOUS ASSAULT BENEFIT		
Benefit Amount	50% of the total amount payable under the following benefits: Covered Injury Death Benefit, Dismemberment, Loss of Speech or Hearing Benefit, Vision Impairment Benefit, Cosmetic Disfigurement from Burns Benefit, Permanent Physical Impairment Benefit, Paralysis Benefit, or Weekly Total or Partial Disability Benefits, subject to an overall maximum benefit of $25,000	50% of the total amount payable under the following benefits: Covered Injury Death Benefit, Dismemberment, Loss of Speech or Hearing Benefit, Vision Impairment Benefit, Cosmetic Disfigurement from Burns Benefit, Permanent Physical Impairment Benefit, Paralysis Benefit, or Weekly Total or Partial Disability Benefits, subject to an overall maximum benefit of $25,000
II.F. IMPAIRMENT MODIFICATION BENEFIT		
Maximum Benefit Amount	actual expenses up to $50,000	actual expenses up to $50,000
II.G. PARALYSIS BENEFIT		
Paralysis Benefit Principal Sum	$50,000	$50,000
Paralysis must occur within	365 days of the Covered Injury or onset of Covered Illness	365 days of the Covered Injury or onset of Covered Illness

SECTION III: INCOME PROTECTION BENEFITS

	Class I	Class II
III.A. WEEKLY TOTAL DISABILITY BENEFITS		
III.A.i. COVERED INJURY MINIMUM WEEKLY TOTAL DISABILITY BENEFIT		
Minimum Weekly Benefit Amount	$100	$100
Maximum Benefit Period	Lifetime	5 Years
III.A.ii. COVERED ILLNESS MINIMUM WEEKLY TOTAL DISABILITY BENEFIT		
Minimum Weekly Benefit Amount	$100	$100
Maximum Benefit Period	Later of Age 67 or Five Years	5 Years
III.A.iii. COVERED INJURY WEEKLY EARNED INCOME REPLACEMENT BENEFIT		
Maximum Weekly Benefit Amount	$700	$700
Maximum Benefit Period	Lifetime	5 Years
III.A.iv. COVERED ILLNESS WEEKLY EARNED INCOME REPLACEMENT BENEFIT		
Maximum Weekly Benefit	$700	$700
Maximum Benefit Period	Later of Age 67 or Five Years	5 Years
III.B. PARTIAL DISABILITY BENEFIT		
Maximum Weekly Benefit	$800	$800
Maximum Benefit Period	Later of Age 67 or Five Years	5 Years
III.C. COST OF LIVING ADJUSTMENT		
Maximum Benefit Amount	$2,400	$2,400
III.D. FIRST WEEK TOTAL DISABILITY BENEFIT		
Maximum Benefit Amount	Weekly Earned Income up to $1,000	Weekly Earned Income up to $1,000
III.E. TRANSITION BENEFIT		
Benefit Amount	$800	$800
Maximum Benefit Period	26 Weeks	26 Weeks
III.F. RETRAINING BENEFIT		
Maximum Benefit Amount	$20,000	$20,000

SECTION IV: MEDICAL EXPENSE BENEFITS

IV.A. MEDICAL EXPENSE BENEFIT

Any benefits limits apply, unless otherwise specified, on a per Insured Person per Covered Injury or Covered Illness basis.

Medical Expense Benefit Options

The shaded box below indicates the Policyholder's selection:

- ☒ Primary Medical Expense other than Workers' Compensation or No-Fault Auto Insurance
- ☐ Full Excess Medical Expense
- ☐ Primary Medical Expense

	Class I	Class II
Maximum Medical Expense Benefit Amount	$10,000	$10,000

IV.B. PLASTIC SURGERY EXPENSE BENEFIT

Maximum Benefit Amount	An additional 25% of the Maximum Medical Expense Benefit Amount for Covered Injury but not less than $25,000	An additional 25% of the Maximum Medical Expense Benefit Amount for Covered Injury but not less than $25,000

SECTION V: ADDITIONAL BENEFITS

	Class I	Class II
V.A. DAILY HOSPITAL CONFINEMENT AND OUTPATIENT TREATMENT BENEFIT		
Daily Benefit Amount	$50	$50
Maximum Benefit Period for Hospital confinement	730 days	730 days
Maximum Benefit Period for treatment after discharge	730 days	730 days
Maximum Benefit Period for treatment without Hospital confinement	365 days	365 days
V.B. DAILY CRITICAL CARE BENEFIT		
Daily Benefit Amount	$100	$100
Maximum Benefit Period	730 days	730 days
V.C. FAMILY EXPENSE BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
V.D. OCCUPATIONAL REHABILITATION BENEFIT		
Maximum Benefit Amount	$5,000	$5,000
V.E. MENTAL STRESS MANAGEMENT BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
V.F. TRAUMATIC INCIDENT BENEFIT		
Traumatic Incident Aggregate Maximum Benefit Amount	$2,500	$2,500
V.G. HEALTH INSURANCE PREMIUM BENEFIT		
Maximum Benefit Amount	$12,000	$12,000

DEFINITIONS

Accident or Accidental means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.

Appropriate Care means the determination of an accurate and medically supported diagnosis of the Insured Person's Total or Partial Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of the Total or Partial Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Auxiliary Member means any person who is a member of the auxiliary to the Sponsoring Organization at the time of Covered Injury or Covered Illness.

Benefit Period means the period, shown on the *Policy Schedule of Benefits,* commencing with the date of the onset of the Total Disability or Partial Disability during which benefits are payable.

Career Personnel means employees or members of the organization that receive Weekly Earned Income for regularly working at least 30 cumulative hours per week as an emergency service provider for the Sponsoring Organization.

Community Volunteer means a non-member who helps the Sponsoring Organization and/or the auxiliary of the organization, in a non-emergency capacity such as fund raisers, banquets, etc.

Cosmetic Disfigurement from Burns means a cosmetic disfigurement that is due to a burn that is classified as a third degree or full-thickness burn caused by a source that is thermal, chemical, electrical, or nuclear. The surface area must be documented by a Physician according to the Rule of Nines or the Lund-Browder chart.

Covered Activity means any activity which is normal for an Insured Person while acting on behalf of the Sponsoring Organization and includes travel directly to and from such activity, as well as impromptu action (Good Samaritan) at the scene of an emergency regardless of the Sponsoring Organization's involvement. Covered Activity includes all athletic events sponsored by the Sponsoring Organization with the exception of Organized League Athletic Events, unless such coverage is purchased.

The Covered Activity must be performed at the direction, or with knowledge, of an officer of the Sponsoring Organization, unless immediate action is required of the Insured Person at the scene of an emergency not on behalf of the Sponsoring Organization or any other organization.

Covered Illness means any disease, sickness or infection, other than those related to psychiatric illness or mental stress, contracted or suffered by an Insured Person during or resulting from a Covered Activity while this Policy is in force.

Covered Illness Death means any Covered Illness, other than those related to psychiatric illness or mental stress, contracted or suffered by an Insured Person during or resulting from a Covered Activity while this Policy is in force which results in the death of an Insured Person.

Covered Injury means Accidental bodily injury sustained by the Insured Person during and/or resulting directly from an Insured Person's participation in a Covered Activity while coverage under the Policy is in force (independent of sickness, disease, mental incapacity or any other cause) and which is not otherwise defined as a Covered Illness.

Covered Injury Death means a Covered Injury sustained by an Insured Person during and/or resulting directly from a Covered Activity while this Policy is in force, and which results in the death of an Insured Person.

Covered Medical Expenses means the Reasonable and Customary Charges for any of the following services: medical or surgical treatment, preventative inoculation, Hospital confinement, Home Healthcare, nursing services prescribed and monitored by a Physician, Post exposure Prophylaxis protocol (PEP) treatment, when such treatment is advised by the attending Physician, Infectious Disease screening test (s), or Post exposure preventive inoculations as a result of participation in a Covered Activity.

CPI-U means the Consumer Price Index for all Urban Consumers, published by the United States Department of Labor. The Company reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Dependent Child means any unmarried child of an Insured Person who is dependent and under the age of 26 upon an Insured Person and claimed on an Insured Person's most current federal tax return or qualified court document showing at least 50% financial responsibility.

Emergency Volunteer means a person physically present at the time of the emergency, and who is not responding/acting as a member of any emergency service organization, who has been specifically requested to assist by the Chief, Line Officer or other officer in charge of the emergency.

Felonious Assault means any willful or unlawful use of force upon an Insured Person:
1. with the intent to cause bodily injury to an Insured Person;
2. that results in bodily harm to an Insured Person; and
3. that is a felony or misdemeanor in the jurisdiction in which it occurs.

Felonious Assault does not include any willful or unlawful use of force upon an Insured Person by another Insured Person.

HIV means Human Immunodeficiency Virus, a virus that infects lymphocytes and other cells bearing the CD4 marker, the initial infection of which is known as acute retro viral syndrome.

Home Healthcare means Medically Necessary services provided and billed by the Home Health Agency. Such services must be prescribed and supervised by a Physician in accordance with a medical treatment.

Home Health Agency means an entity engaged in arranging and providing nursing services, home health services or other therapeutic and related services. The entity and must be certified by a competent governmental authority in the jurisdiction where the services are rendered, as meeting requirement of Title XVIII of the Social Security Act, as amended, for home health agencies.

Hospital means an institution that meets all of the following:
1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics; or
3. a Veteran’s Administration Hospital or Federal Government Hospital unless the Insured Person incurs an expense.

Infectious Disease means a disease included within the list of potentially life-threatening infectious diseases, developed by the Secretary of Health and Human Services, pursuant to Title XXVI of the Public Health Service Act.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), grandparent, grandchild, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, or father-in-law.

Inpatient means confined overnight as a registered bed-patient in a Hospital or other medical facility where at least one day’s room and board is charged. The confinement must be on the advice of a Physician.

Insured Person means any person who is listed as an Eligible Person on the *Policy Schedule of Benefits*.

Loss of Earnings Coverage means any disability benefits or salary continuance received from:
1. the benefits payable in accordance with any Workers' Compensation Act or Occupational Disease Act or Law, or any other law which provides compensation for an occupational injury;
2. the income benefit provided by or through any automobile insurance plan or any government plan of automobile insurance or similar insurance regulation or law;
3. the salary continuation or severance allowance provided by or through the employer;
4. the disability, retirement or other income benefits provided by or through the employer, the Sponsoring Organization, or the Insured Person; and
5. the amounts paid or payable under any group plan or insurance policy.

Loss of Earnings Coverage does not include disability benefits received from individual disability insurance paid by Insured Person, or any disability benefits payable under the United States Federal Social Security Act. If an Insured Person settles a Workers' Compensation claim, including Loss of Earnings or similar provisions of Workers' Compensation, the presumed amount of those Workers' Compensation benefits shall be considered Loss Earnings Coverage for the entire duration of the Insured Person's Total Disability or Partial Disability.

Medically Necessary means medical services that: (1) are essential for diagnosis, treatment or care of the Covered Injury or Covered Illness for which it is prescribed or performed; (2) meet generally accepted standards of medical practice; and (3) are ordered by a Physician and performed under his or her care, supervision or order.

Nurse means a licensed graduate registered Nurse (R.N.) or a licensed practical Nurse (L.P.N.) who is not:
1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household; or
4. a person employed or retained by the Sponsoring Organization.

Organized League Athletic Event means any type of sporting event or activity that occurs during a pre-planned schedule of practices, games, matches and/or tournaments over a specific season and may include the usage of a team roster, designated uniforms, umpires/referees, or fees paid to participate.

Other Valid and Collectible Insurance means: (1) any group plan, program or insurance policy; (2) any other group hospital, surgical or medical benefit plan; or (3) any union welfare plan or group employer or employee benefit program. Other valid and collectible insurance will not include benefits provided by the United States Social Security Act or any individual disability insurance plan.

Outpatient means an Insured Person who is a patient and is not hospitalized overnight but who visits a Hospital, clinic, or associated facility for diagnosis or treatment.

Paralysis/Paralyzed means Quadriplegia, Paraplegia, Hemiplegia or Uniplegia that is expected to last for a continuous period of 12 months or more from the earlier of the date of the Covered Activity that caused the Paralysis or the date of the diagnosis. "Quadriplegia" means the complete and irreversible Paralysis of both upper and lower limbs. "Paraplegia" means the complete and irreversible Paralysis of both lower limbs or both upper limbs. "Hemiplegia" means the complete and irreversible Paralysis of the upper and lower limbs of the same side of the body. "Uniplegia" means the complete and irreversible paralysis of one limb. "Limb" means entire arm or entire leg.of the body.

Partial Disability or Partially Disabled means, for an Insured Person with an occupation producing wages as described in the definition of Weekly Earned Income, the inability to perform one or more, but not all, of the material and substantial duties of his or her own occupation as a result of a Covered Injury or Covered Illness.

If an Insured Person does not have an occupation producing wages as described in the definition of Weekly Earned Income, Partial Disability or Partially Disabled means:
1. the inability to perform one or more, but not all of the material and substantial duties of an occupation for which an Insured Person is qualified by reason of education, training or experience; or
2. the inability to perform one or more, but not all of the regular activities of an Insured Person.

An Insured Person must be under the regular care of a Physician during Partial Disability.

Permanent Physical Impairment means a physical impairment or functional abnormality of a body part or parts or loss of at least 10% whole person which remains after maximum medical rehabilitation has been achieved and which is considered stable or non-progressive by the examining Physician at the time of evaluation.

Physician means a licensed health care provider practicing within the scope of his or her license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:
1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's spouse;
3. a person living in the Insured Person's household;
4. a person employed or retained by the Sponsoring Organization; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Police Reserve Officers means all officers and reserve law enforcement members appointed by the Policyholder. Such persons have completed or are actively enrolled and participating in, the training and probationary period specified by the written regulations of the Policyholder.

Policy Term means the time period defined for the Policyholder shown on the *Policy Schedule of Benefits.*

Reasonable and Customary Charge(s) means a charge that:
1. is made for a Covered Medical Expense;
2. does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit or a cardiac care unit, does not exceed the Hospital's most common charge for semi-private room and board); and
3. does not include charges that would not have been made if no insurance existed.

Reasonable Occupation means any occupation for which an Insured Person is reasonably fitted based on education, training or experience and an Insured Person could expect to generate the lesser of $75,000 annually or at least 70% of his or her Weekly Earned Income.

Regular Occupation means the Insured Person's primary occupation at the time of disability for which he or she was receiving remuneration.

Review Date means the date after 52 weeks of continuous disability.

Spouse means the Insured Person's lawful spouse.

Supplemental Restraint System means any airbag that inflates upon impact for added protection to the head and chest areas.

Total Disability or Totally Disabled means that for the first 5 years from the date of a Covered Injury or onset of a Covered Illness, an Insured Person:
1. is not able to perform the substantial and material duties of his or her occupation; and
2. is receiving Appropriate Care.

After 5 years from the date of a Covered Injury or onset of a Covered Illness, Total Disability or Totally Disabled means that due to a Covered Injury or a Covered Illness an Insured Person:
1. is not able to engage in any Reasonable Occupation;
2. is not working at any other occupation; and
3. is receiving Appropriate Care.

Traumatic Incident means an abnormal experience involving the Sponsoring Organization, outside the range of usual human experiences and that includes: 1) line of duty death or serious injury to other Insured Persons; 2) a single incident having multiple casualties; 3) death or serious injury of a child; 4) dealing with victims known to the Insured Person; and 5) similar incidents that would reasonably require mental health care for the entire Sponsoring Organization or a significant number of members of the Sponsoring Organization.

Traumatic Incident Stress Management Team means an organized group of mental health professionals and peer support individuals trained to provide support services to emergency service organization personnel. Such support services include traumatic incident stress defusing, debriefing, demobilization, stress reduction education, spousal support, one-on-one interviews, or on-the-scene support.

Weekly Earned Income means the greater of an Insured Person's:
1. average income earned on a weekly basis at the time the disability starts; or
2. average income earned on a weekly basis for the period of one year prior to the start of disability for which a claim is made.

If an employer, other than himself, employs an Insured Person, Weekly Earned Income will be computed from an Insured Person's regular, over-time and shift differential wages. Weekly Earned Income shall be substantiated by pay stubs, W-2 Forms, other employment records, tax records, and/or other records which We may reasonably request. Commission earnings will be computed using an average of 24 months of previous commission earnings.

If an Insured Person is self-employed, Weekly Earned Income will be computed from the amount reported by an Insured Person on page 1 of the IRS Form 1040 series, which includes amounts from Schedules C and F, and from qualifying income from Schedule E which is included in the amount reported by an Insured Person on page 1 of IRS Form 1040 series.

If the Insured Person is a commissioned sales person, Weekly Earned Income will be any salary or wages and commissions received from the Employer. This will be based on the Statement of Wages Earned and Taxes Withheld (Form W-2) for the fiscal year ending immediately prior to the date of the Insured Person’s disability.

Weekly Earned Income does not include rent, royalties, investment income, passive income, estate and trust income and REIT/REMIC income regardless of an Insured Person's active involvement in generating said forms of income, an Employer's contributions to any deferred compensation plan or pension plan on the Insured Person’s behalf, stock options, or any other income not derived directly from an Insured Person's occupational activities.

GENERAL EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided in the Policy:

1. declared or undeclared war or act of war;
2. suicide or any attempt at it, while sane or insane; or intentionally self-inflicted injuries while sane;
3. mental or emotional disorders, except as specifically provided for by the Traumatic Incident Benefit or the Mental Stress Management Benefit;
4. any Organized League Athletic Event, except as provided under the Policy; or
5. commission of a felony.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. employed or retained by Sponsoring Organization;
2. living in the Insured Person's household;
3. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse; or
4. the Insured Person.

LIMITATIONS

The benefits contained in this policy are subject to the following limitations:

1. all Covered Injuries and Covered Illnesses arising from the same Covered Activity shall be treated as a single Covered Injury or Covered Illness. If the Insured Person sustained a Covered Injury and a Covered Illness from the same Covered Activity and the amount payable or benefit period for a specific benefit is different for Covered Injuries and Covered Illnesses, the Company will pay the higher amount or adhere to the longer benefit period.

2. if an Insured Person suffers a Covered Injury or Covered Illness that is payable under more than one of the following benefits, the most the Company will pay is the greater of the largest principal sum or the largest single benefit amount payable shown on the *Policy Schedule of Benefits* for any benefit for which the Insured Person qualifies:
   - Covered Injury Death Benefit;
   - Covered Illness Death Benefit;
   - HIV Positive Diagnosis Lump Sum Benefit;
   - Dismemberment, Loss of Speech or Hearing Benefit;
   - Vision Impairment Benefit;
   - Permanent Physical Impairment Benefit; or
   - Paralysis Benefit.

3. if an Insured Person is covered under more than one Policyholder Blanket Accident Policy issued by the Company, the total benefits payable will not exceed those payable under the policy that provides the greatest benefit.

Section I: DEATH BENEFITS

I.A. COVERED INJURY DEATH BENEFIT
If an Insured Person sustains a Covered Injury that directly causes the loss of life, the Company will pay the Principal Sum shown on the *Policy Schedule of Benefits*.

I.B. COVERED ILLNESS DEATH BENEFIT
If an Insured Person suffers a Covered Illness that directly causes the loss of life, the Company will pay the Principal Sum shown on the *Policy Schedule of Benefits*.

I.C. HIV POSITIVE DIAGNOSIS LUMP SUM BENEFIT
If an Insured Person tests positive for HIV as a direct result of participation in a Covered Activity, the Company will pay the Benefit Amount shown on the *Policy Schedule of Benefits.*

An Insured Person may choose, as an option, to receive this benefit in lieu of the Permanent Physical Impairment Benefit, Covered Illness Death Benefit or Covered Injury Death Benefit.

If an Insured Person receives this benefit, the Covered Injury Death Benefit, Covered Illness Death Benefit, or Permanent Physical Impairment Benefit will not be applicable for the same Covered Activity.

I.D. BEREAVEMENT BENEFIT
If a Covered Injury Death Benefit or Covered Illness Death Benefit is payable under this Policy, an amount up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* will be paid for out-of-pocket expenses actually incurred by the Policyholder or Participating Organization for the following expenses that are directly associated with an Insured Person's loss of life: 1) reasonable cost of bereavement counseling and 2) the reasonable costs associated with the memorial service, wake, honor guard, or other tribute to the Insured Person. This benefit is payable to the Policyholder or Participating Organization.

Any such payments made in good faith will fully discharge us to the extent of such payment.

I.E. DEPENDENT CHILD BENEFIT
If a Covered Injury or Covered Illness Death Benefit is payable under the Policy, the Company shall pay the Benefit Amount shown on the *Policy Schedule of Benefits* for each Dependent Child. The Dependent Child Benefit is payable in addition to the Covered Injury Death Benefit or Covered Illness Death Benefit and other losses payable under this Policy.

The Benefit Amount will be paid directly to the Insured Person’s beneficiary.

Payment made in this manner will release the Company from all liability to the extent of any payment made.

I.F. SEATBELT AND AIRBAG BENEFIT
If a Covered Injury Death Benefit is payable under this Policy and the Insured Person’s death occurred in an Accident while he or she was wearing a properly fastened automobile seatbelt, the Company will pay the Seatbelt Benefit Amount shown on the *Policy Schedule of Benefits*. If the Seatbelt Benefit is payable, the additional Airbag Benefit Amount shown on the *Policy Schedule of Benefits* will be paid if the Insured Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag) when the Accident occurred.

This Seatbelt Benefit is not payable for Covered Injury sustained by an Insured Person while standing inside or on the tailboard of any vehicle.

Administrative Address:
AXIS Insurance Company
1 University Square Drive, Suite 200
Princeton, NJ 08540
888.870.AXIS (2947)
General questions - please send to USSales.AccHealth@axiscapital.com

Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective June 1, 2011

I.G. FINAL EXPENSES BENEFIT
If a Covered Injury or Covered Illness Death Benefit is payable under this Policy, an amount up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* will be paid for the following out-of-pocket expenses actually incurred by the beneficiary for expenses directly associated with an Insured Person's loss of life: all expenses related to the funeral and burial of the Insured Person, including transfer of the remains to the funeral home, all services of the Funeral Director and staff, embalming, dressing cosmetology and hair, use of the funeral home, printing and design cost use of the hearse and any limousines, cost of the casket, burial vault, cemetery charges including the grave, opening grave site, head stone and other items such as tents for protection from the weather, cremation expenses including transfer of the remains to the crematorium, and travel and other expenses of the Immediate Family, and all other expenses reasonably related to funeral services for an Insured Person of the Sponsoring Organization.

This benefit will be payable, at our option in good faith, to the individual who paid for the covered expenses or who is financially responsible for paying such expenses.

I.H. SPOUSAL BENEFIT
If a Covered Injury Death Benefit or Covered Illness Death Benefit is payable under the Policy, the Company shall pay the Benefit Amount shown on the *Policy Schedule of Benefits* to the Spouse of the deceased Insured Person.

I.I. SURVIVING SPOUSE EDUCATION BENEFIT
If an Insured Person suffers a Covered Injury Death or Covered Illness Death, the Company shall reimburse the surviving Spouse expenses incurred to enroll in an institution of higher learning or professional or trade training program, subject to the following conditions:

- The Company must approve the program in advance, which must be designed to teach or train the Spouse with the skills necessary to work in an occupation after the completion of the program;
- The Company and Spouse must enter into a written agreement detailing the program, costs and expected progress of the Insured Person;
- The Company will review the program and the progress of the Spouse at the end of each of the institution's term and will only continue to pay for the program if it meets the goals set out at the beginning of the program; and
- This Spouse must begin the program within 1 year of the Insured Person's death.

The Company shall reimburse the Spouse at the end of each year for tuition, books and supplies charged by the institution up the Maximum Annual Benefit Amount shown on the *Policy Schedule of Benefits* for a period of time not exceed the Maximum Benefit Period or Maximum Benefit Amount shown in the *Policy Schedule of Benefits*. The Company shall not pay for expenses incurred by the Insured Person for which he or she is reimbursed by another source.

I.J. DEPENDENT CHILD EDUCATION BENEFIT
If an Insured Person suffers a Covered Injury Death or Covered Illness Death and a death benefit is payable under this Policy, the Company will pay expenses incurred by each Dependent Child for tuition, fees, books, room and board, transportation and any other costs payable directly to a school, or approved and certified by the school, up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits***.**

In order to qualify for benefits, a qualifying Dependent Child must:

1. be a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the Insured Person's death, or begin studies as a full-time student at a school of higher learning within 2 years of the Insured Person's death and before reaching the limiting age shown in the Dependent Child definition; and
2. continue His education as a full-time student in such accredited school of higher learning.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian if the child is a minor, at the end of each year up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits*. The Company must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a benefit is payable will begin on the first of the month following the date the Insured Person died, if the surviving Dependent Child was a full-time student on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he or she begins studies in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

Section II: IMPAIRMENT BENEFITS

II.A. DISMEMBERMENT, LOSS OF SPEECH OR HEARING BENEFIT

If an Insured Person sustains a Covered Injury that directly causes any of the Losses shown in the Table of Losses below, the Company will pay the Benefit Amount shown for the Loss. If more than one Loss results from the same Accident, the maximum amount payable is the Principal Sum. Unless provided otherwise in this Policy, these benefits will be paid in addition to any other payment for a Covered Injury or Covered Illness to which an Insured Person may be entitled under this Policy.

Loss of hand or foot means complete severance through or above the wrist or ankle. Loss of arm or leg means complete severance through or above the elbow or knee joint. Loss of thumb or index finger means actual severance through or above the metacarpi-phalange joints. Loss of second, third or fourth finger of either hand means actual severance of two or more phalanges. However, if one complete phalange but less than two phalanges is severed, the Company will pay 50% of the percentage shown for this loss shown in the Table of Losses below. Loss of speech means the entire and irrecoverable loss of the entire ability to speak. Complete loss of hearing means the entire and irrecoverable loss of the entire ability to hear in both ears.

When medical expenses are incurred in an effort to prevent one of these Losses, the amount payable for such Loss may be used for such medical expenses if the Maximum Medical Expense Benefit Amount shown on the *Policy Schedule of Benefits* has been paid. Any benefits paid for medical expenses in excess of the Maximum Medical Expense Benefit Amount will be deducted from the benefits payable under this benefit if the medical treatment fails to prevent the specific Loss.

Table of Losses

Loss	Benefit Amount
Loss of Both Hands or Both Feet	100% of the Impairment Principal Sum
Loss of One Hand and One Foot	100% of the Impairment Principal Sum
Complete Loss of Speech	100% of the Impairment Principal Sum
Complete Loss of Hearing in Both Ears	100% of the Impairment Principal Sum
Loss of One Arm or One Leg	75% of the Impairment Principal Sum
Loss of One Hand	50% of the Impairment Principal Sum
Loss of One Foot	50% of the Impairment Principal Sum
Loss of Thumb or Index Finger of Either Hand	25% of the Impairment Principal Sum
Loss of Second, Third or Fourth Finger of Either Hand	12.5% of the Impairment Principal Sum
Loss of any Joint on Either Finger or Toe	6.25% of the Impairment Principal Sum

II.B. VISION IMPAIRMENT BENEFIT

If an Insured Person suffers a vision impairment due to a Covered Injury or Covered Illness, the Company will pay a Vision Impairment Benefit for each impaired eye. The amount of the Vision Impairment Benefit for each eye shall be the product of the Percentage of Vision Impairment Principal Sum corresponding to the Degree of Vision Impairment as shown below, multiplied by the Vision Impairment Principal Sum shown in the *Policy Schedule of Benefits*.

If an Insured Person's sight was less than 20/20 before the Covered Injury or Covered Illness the Company will measure the vision impairment based upon the additional impairment measured after the Covered Injury or Covered Illness. Loss of Sight means the permanent, irrecoverable loss of the entire sight in that eye.

Vision Impairment Chart

Degree of Vision Impairment	Percentage of Vision Impairment Principal Sum Payable for Each Eye
20/20	0.00%
20/30	2.75%
20/40	5.50%
20/50	8.25%
20/60	11.00%
20/80	16.50%
20/100	22.00%
20/120	28.00%

Degree of Vision Impairment	Percentage of Vision Impairment Principal Sum Payable for Each Eye
20/150	36.00%
20/180	45.50%
20/200 or worse	50.00%
Loss of Sight of Both Eyes (20/200 or worse in both eyes)	100%
Loss of Sight of One Eye (20/200 or worse)	50.00%

II.C. COSMETIC DISFIGUREMENT FROM BURNS BENEFIT

If an Insured Person suffers Cosmetic Disfigurement from Burns as a result of a Covered Injury, the Company will pay a benefit payable based on the following formula:

1. determination of the Area Classification Factor for the burned area as set forth in the Cosmetic Burns Schedule as shown below;
2. the Area Classification Factor is multiplied by the percentage of body surface actually burned, up to the Maximum Allowable Percentage for Area Surface Burned for each Area Classification Factor as shown on the Cosmetic Burns Schedule, and as determined by the attending Physician; and
3. steps 1 and 2 above determine a percentage, which is then multiplied by the Cosmetic Disfigurement from Burns Principal Sum as shown on the *Policy Schedule of Benefits.*

This benefit will be paid in addition to any other benefit payable under this Policy with the exception of a benefit paid under the Dismemberment, Loss of Speech or Hearing Benefit for the same area burned.

If an Insured Person suffers burns in more than one area as a result of any one Covered Activity, the calculation above shall be performed for each burned area. The maximum amount payable under this benefit shall not exceed 100% of the Cosmetic Disfigurement from Burns Principal Sum.

Cosmetic Burns Schedule

Body Part	Area Classification Factor	Maximum Allowable Percentage for Area Surface Burned	Percentage of Cosmetic Disfigurement From Burns Principal Sum *
Face, Neck, Head	11	9%	100%
Hand & Forearm (Right)	5	4.5%	22.5%
Hand & Forearm (Left)	5	4.5%	22.5%
Upper Arm (Right)	3	4.5%	13.5%
Upper Arm (Left)	3	4.5%	13.5%
Torso (Front)	2	18%	36%
Torso (Back)	2	18%	36%
Thigh (Right)	1	9%	9%
Thigh (Left)	1	9%	9%
Lower Leg (Right/below knee)	3	9%	27%
Lower Leg (Left/below knee)	3	9%	27%

*The percentage shown is based on 100% of the Body Part identified being burned.

II.D. PERMANENT PHYSICAL IMPAIRMENT BENEFIT

If an Insured Person suffers a Covered Injury or Covered Illness that results in a Permanent Physical Impairment of a body part, the Company will pay a Permanent Physical Impairment Benefit as shown on the *Policy Schedule of Benefits.*

The amount of the Permanent Physical Impairment Benefit will be determined by the product of the impairment percentage assigned by an examining Physician of Our choice, multiplied by the Permanent Physical Impairment Principal Sum. The impairment value shall be expressed as a percentage, taking into account the body part(s) permanently impaired as that part(s) relates to an Insured Person's whole person. The examining Physician will determine the impairment percentage by using the American Medical Association's *"Guide to Evaluation of Permanent Impairment"* most current at the time of the claim.

If an Insured Person had a pre-existing physical impairment prior to the Covered Injury or Covered Illness, the impairment value of the pre-existing physical impairment will be deducted from the impairment value calculated after the Covered Injury or Covered Illness in order to determine the amount of the Permanent Physical Impairment Benefit.

If an Insured Person suffers a Covered Injury or Covered Illness that results in over 90% Permanent Physical Impairment, the Company will pay 125% of the Permanent Physical Impairment Benefit as shown on the *Policy Schedule of Benefits*.

II.E. FELONIOUS ASSAULT BENEFIT

If an Insured Person suffers a Covered Injury as a result of a Felonious Assault that is directed at the Insured Person while participating in a Covered Activity, the Company will pay an additional benefit as shown on the *Policy Schedule of Benefits* if any of the following benefits are payable for the same Covered Injury:

- Covered Injury Death Benefit;
- Dismemberment, Loss of Speech or Hearing Benefit;
- Vision Impairment Benefit;
- Cosmetic Disfigurement From Burns Benefit;
- Covered Injury Permanent Physical Impairment Benefit;
- Paralysis Benefit; or
- After 26 consecutive weeks of Weekly Total Disability or Partial Disability Benefits, beginning after the end of the 26th week, the Company will pay an additional weekly benefit as shown in the *Policy Schedule of Benefits*.

II.F. IMPAIRMENT MODIFICATION BENEFIT

If, due to Total Disability or Partial Total Disability, an Insured Person sustains a permanent physical limitation or impairment that poses a safety risk or inhibits an Insured Person's ability to maintain independence in his or her current transportation or living situation, the Company will pay the reasonable cost of the following Impairment Modifications:

1. alterations to an Insured Person's residence to make it wheelchair accessible and/or habitable; and
2. modifications necessary to a motor vehicle, owned by an Insured Person, to make the vehicle accessible or operable for an Insured Person.

The Impairment Modifications:

1. must be subject to a written agreement between the Insured Person and the Company which includes the costs and reasons for the modifications;
2. do not include charges that would not have been absent insurance; and
3. only include amounts incurred by the Insured Person for which he or she is not reimbursed by another source.

II.G. PARALYSIS BENEFIT

If an Insured Person suffers Paralysis resulting from a Covered Injury or Covered Illness, the Company will pay a Paralysis Benefit, provided that the Paralysis occurs within the time period from the Covered Injury or Covered Illness shown on the *Policy Schedule of Benefits*. The Benefit Amount is based on the type of Paralysis and shall be equal to the benefit percentage for that type of Paralysis shown below multiplied by the Paralysis Principal Sum shown in the *Policy Schedule of Benefits.*

Paralysis	Benefit Amount
Quadriplegia	125% of the Paralysis Benefit Principal Sum
Paraplegia	75% of the Paralysis Benefit Principal Sum
Hemiplegia	75% of the Paralysis Benefit Principal Sum
Uniplegia	75% of the Paralysis Benefit Principal Sum

Section III: INCOME PROTECTION BENEFITS

III.A. WEEKLY TOTAL DISABILITY BENEFITS

III.A.i. COVERED INJURY MINIMUM WEEKLY TOTAL DISABILITY BENEFIT
If an Insured Person is Totally Disabled as the result of a Covered Injury, the Company will pay the Minimum Weekly Benefit Amount shown on the *Policy Schedule of Benefits.* The Weekly Total Disability Benefit shall be payable for a period up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Injury.

III.A.ii. COVERED ILLNESS MINIMUM WEEKLY TOTAL DISABILITY BENEFIT
If an Insured Person is Totally Disabled as the result of a Covered Illness, the Company will pay the Minimum Weekly Benefit Amount shown on the *Policy Schedule of Benefits*. The Weekly Total Disability Benefit shall be payable for a period up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Illness.

III.A.iii. COVERED INJURY WEEKLY EARNED INCOME REPLACEMENT BENEFIT
If an Insured Person is Totally Disabled as a result of a Covered Injury and the Minimum Weekly Total Disability Benefit Amount is being paid, the Company will pay a Covered Injury Weekly Earned Income Replacement Benefit.

The amount of the Covered Injury Weekly Earned Income Replacement Benefit shall be computed as follows:
the Insured Person's Weekly Earned Income less the combined total of:
a. the Covered Injury Minimum Weekly Total Disability Benefit Amount; and
b. the Loss of Earnings Coverage.

In no event will the Covered Injury Weekly Earned Income Replacement Benefit exceed the Maximum Weekly Benefit Amount shown on the *Policy Schedule of Benefits*.

The Covered Injury Weekly Earned Income Replacement Benefit will be paid for the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Injury.

III.A.iv. COVERED ILLNESS WEEKLY EARNED INCOME REPLACEMENT BENEFIT
If an Insured Person is Totally Disabled and the Covered Illness Minimum Weekly Total Disability Benefit is being paid, the Company will pay a Covered Illness Weekly Earned Income Replacement Benefit.

The amount of the Covered Illness Weekly Earned Income Replacement Benefit shall be computed as follows:
the Insured Person's Weekly Earned Income less the combined total of:
a. the Covered Illness Minimum Weekly Total Disability Benefit Amount; and
b. the Loss of Earnings Coverage.

In no event will the Covered Illness Weekly Earned Income Replacement Benefit exceed the Maximum Weekly Benefit Amount shown on the *Policy Schedule of Benefits.*

The Covered Illness Weekly Earned Income Replacement Benefit will be paid for the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Totally Disabled as a result of the Covered Illness.

III.B. PARTIAL DISABILITY BENEFIT
If an Insured Person suffers a Covered Injury or Covered Illness that results in a Partial Disability, the Company will pay a Partial Disability Benefit, as provided on the *Policy Schedule of Benefits*, if an Insured Person returns to any Reasonable Occupation at lower rate of Weekly Earned Income than he or she was earning prior to becoming Totally Disabled or Partially Disabled.

The Weekly Benefit Amount shall be computed as follows:
the Insured Person's Weekly Earned Income less the combined total of:
a. earnings from any Reasonable Occupation; and
b. the Loss of Earnings Coverage.

In no event will the Partial Disability Benefit exceed the Maximum Weekly Benefit Amount shown on the *Policy Schedule of Benefits.*

The Partial Disability Benefit will be paid for the Maximum Benefit Period shown on the *Policy Schedule of Benefits,* provided the Insured Person remains Partially Disabled as a result of the Covered Injury or Covered Illness.

If an Insured Person is approved for disability retirement or otherwise retires, all eligibility for Partial Disability terminates on the effective date of such retirement.

III.C. COST OF LIVING ADJUSTMENTS
After each Review Date, the Company will make Cost of Living Adjustments as set forth below:

If only the Covered Injury or Covered Illness Minimum Weekly Total Disability Benefit is payable, the Company will increase the benefit then payable by the greater of (a) 5% or (b) the CPI-U at the time. In no event will the increase exceed 8%.

If the Covered Injury or Covered Illness Minimum Weekly Total Disability Benefit and the Covered Injury or Covered Illness Weekly Earned Income Replacement Benefits are payable, the Company will increase the combined benefit then payable by the greater of (a) 5% or (b) the CPI-U at the time, of the Weekly Earned Income at the time the Insured Person's Disability began. In no event will the increase exceed 8%.

If, for 52 consecutive weeks, disability benefits are payable through a combination of the Covered Injury or Covered Illness Minimum Weekly Total Disability Benefit, Covered Injury or Covered Illness Weekly Earned Income Replacement Benefit, Partial Disability Benefits, or only Partial Disability Benefits, the company will increase the average weekly benefit paid during the prior 52 weeks by the greater of (a) 5% or (b) the CPI-U at the time. In no event will the increase exceed 8%.

These adjustments will be made after each Review Date and will be compounded. Any increased benefits apply to the 52 weeks of continuous disability immediately following the date of adjustment. In no event will any computed benefit exceed three (3) times the Maximum Covered Injury or Covered Illness Weekly Total Disability Benefit Amount shown on the *Policy Schedule of Benefits.*

III.D. FIRST WEEK TOTAL DISABILITY BENEFIT
For the first week that an Insured Person is Totally Disabled due to a Covered Injury or Covered Illness, the Company will pay a First Week Disability benefit that shall be computed as follows:

the Insured Person's Weekly Earned Income less the combined total of:
a. the Covered Injury or Covered Illness Minimum Weekly Total Disability Benefit;
b. the Covered Injury or Covered Illness Weekly Earned Income Replacement Benefit; and
c. Loss of Earnings Coverage.

In no event will the First Week Total Disability Benefit exceed the Maximum First Week Disability Benefit Amount shown on the *Policy Schedule of Benefits.*

III.E. TRANSITION BENEFIT
If an Insured Person is given a release to return to his or her primary employer after having received Weekly Total Disability Payments, Earned Income Replacement Weekly Total Disability Payments, or Partial Disability Payments under this Policy for a Covered Injury or Covered Illness, but his or her primary employer has terminated his or her employment due to the Covered Injury or Covered Illness that led to the Total Disability or Partial Disability, the Company will continue to pay disability benefits previously payable under this Policy for a period of up to the Maximum Benefit Period shown on the *Policy Schedule of Benefits* while an Insured Person actively seeks employment.

III.F. RETRAINING BENEFIT

If an Insured Person, as a result of a Covered Injury or Covered Illness, cannot find and maintain a Regular Occupation, the Company will pay for the Insured Person to enroll in an institution of higher learning or professional or trade training program, subject to the following conditions:

- the Company must approve the program in advance, which must be designed to teach or train the Insured Person with skills to obtain a Reasonable Occupation;
- the Company and Insured Person must enter into a written agreement detailing the program, costs and expected progress of the Insured Person; and
- the Company will review the program and the progress of the Insured Person at the end of each of the institution's term and will only continue to pay for the program if it meets the goals set out at the beginning of the program.
- The Company shall pay the actual costs incurred by the Insured Person for tuition, books and supplies charged by the institution up the Maximum Benefit Amount shown on the *Policy Schedule of Benefits*. The Company shall not pay for expenses incurred by the Insured Person for which he or she is reimbursed by another source.
- Participation in the program by an Insured Person will not, in and of itself, be considered a recovery from a Total Disability or Partial Disability. Benefits for disability will continue as provided by the Policy while an Insured Person is actively participating in the program.

EXCLUSIONS THAT APPLY TO THE INCOME PROTECTION BENEFITS

In addition to the Exclusions provided under the Policy, no Income Protection Benefits shall be payable in the following instances, unless coverage is specifically provided:

1. during the Insured Person's incarceration in a penal or corrections institution. Payments may resume after incarceration as long as the Insured Person remains Totally Disabled and remains covered under the Policy; or
2. the Insured Person is not receiving Appropriate Care.

LIMITATIONS

1. Total Disability or Partial Disability claims resulting from athletic events that are not Organized League Athletic Events will be limited to a maximum period of up to 156 weeks.
2. In no event will benefits be payable to an Insured Person for more than one disability at the same time.
3. An Insured Person may reopen his or her claim at any time up to 5 years following a period of Total Disability or Partial Disability for either Covered Injuries or Covered Illnesses for which payments were made under this Policy.
4. If an Insured Person is covered by multiple Accident Policies issued by the Company, the total amount of Income Protection Benefits payable under all policies will be a weekly benefit amount up to a maximum of $1,000.

Section IV: MEDICAL EXPENSE BENEFITS

IV. A. MEDICAL EXPENSE BENEFIT

The Company will pay 100% of the Reasonable and Customary Charges for the Covered Medical Expenses incurred by an Insured Person as a result of a Covered Injury or Covered Illness. The amount payable will be subject to the following conditions and limitations:

- The Company shall not pay more than the Maximum Medical Expense Benefit Amount shown on the *Policy Schedule of Benefits* for all Covered Medical Expenses resulting from the same Covered Injury or Covered Illness.
- The Company may have a different Maximum Medical Expense Benefit Amount depending on whether the Covered Medical Expenses result from a Covered Injury or Covered Illness. The different amounts, if any, are contained on the *Policy Schedule of Benefits.*

IV. B. PLASTIC SURGERY EXPENSE BENEFIT

If the Insured Person incurs expenses that exceed the Maximum Medical Expense Benefit Amount provided under the Medical Expense Benefit as shown on the *Policy Schedule of Benefits*, the Company shall provide an additional amount for Covered Medical Expenses incurred for plastic surgery that is Medically Necessary due to a Covered Injury. The additional amount is a percentage of the Maximum Medical Expense Benefit Amount provided under the Medical Expense Benefit and is shown on the *Policy Schedule of Benefits.*

EXCLUSIONS FOR MEDICAL EXPENSE BENEFIT AND THE PLASTIC SURGERY EXPENSE BENEFIT

In addition to the Exclusions provided under the Policy, no Medical Expense Benefit or Plastic Surgery Expense Benefits shall be payable for the following treatments or services, unless coverage is specifically provided:

1. benefits paid or payable under any Workers' Compensation Act or similar law, or under any no fault automobile insurance plan or similar law. If an Insured Person settles a Workers' Compensation claim, including medical expenses under Workers' Compensation, medical expenses rising from the injury or occupational disease that led to the Workers' Compensation claim will be deemed to be payable under Workers' Compensation for purpose of determining Covered Medical Expenses; or
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States.

Other exclusions that apply to this benefit are in the General Exclusions section.

Section V: ADDITIONAL BENEFITS

V.A. DAILY HOSPITAL CONFINEMENT AND OUTPATIENT TREATMENT BENEFIT

If, due to a Covered Injury or Covered Illness, an Insured Person is admitted to a Hospital on an Inpatient basis, the Company will pay the Daily Benefit Amount shown on the *Policy Schedule of Benefits* for each full day an Insured Person is confined as an Inpatient to the Hospital. The number of days payable under this benefit will not exceed the Maximum Benefit Period for Hospital confinement shown on the *Policy Schedule of Benefits*.

Treatment after Discharge

If, after a period of being confined as an Inpatient in a Hospital due to a Covered Injury or Covered Illness, an Insured Person requires Outpatient physical therapy, rehabilitation or follow-up Physician visits for the treatment of the Covered Injury or Covered Illness, the Company will pay the Daily Benefit Amount for each day of such Outpatient treatment. The number of days payable under this benefit will not exceed the Maximum Benefit Period for treatment after discharge shown on the *Policy Schedule of Benefits.* The Company will only make one payment per day, regardless of the number of appointments an Insured Person attends on any given day.

Treatment without Hospital Confinement

If, due to a Covered Injury or Covered Illness, an Insured Person does not require confinement as an Inpatient in a Hospital, but does require Outpatient physical therapy, rehabilitation and/or follow-up Physician visits, the Company will pay the Daily Benefit Amount shown on the *Policy Schedule of Benefits* for each day of such Outpatient treatment. The number of days payable under this benefit will not exceed the Maximum Benefit Period for treatment without Hospital confinement shown on the *Policy Schedule of Benefits*. The Company will only make one payment per day, regardless of the number of appointments an Insured Person attends on any given day.

V.B. DAILY CRITICAL CARE BENEFIT

If, due to a Covered Injury or Covered Illness, an Insured Person is Hospital confined to an intensive care, trauma, critical care, burn or similar specialty unit, the Company will pay the Daily Benefit Amount shown in the *Policy Schedule of Benefits* for each full day of such confinement. The number of days payable under this benefit will not exceed the Maximum Benefit Period shown on the *Policy Schedule of Benefits*. This payment is in lieu of the Daily Hospital Confinement Benefit.

V.C. FAMILY EXPENSE BENEFIT

If, as a result of a Covered Injury or Covered Illness, an Insured Person requires medical treatment that causes an Immediate Family Member or a significant other to accompany an Insured Person for treatment or to help treat an Insured Person, the Company will pay the following reasonable expenses actually incurred by the Immediate Family Member or significant other and not reimbursed by another source: loss of wages, out of pocket expenses, hotel accommodations, parking, childcare or other expenses reasonably related to treatment or care of the Insured Person. The most the Company will pay under this benefit is the Maximum Family Expense Benefit Amount shown on the *Policy Schedule of Benefits*.

V.D. OCCUPATIONAL REHABILITATION BENEFIT

If an Insured Person is receiving Weekly Total Disability Benefits or Partial Disability Benefits, he or she may be eligible for a rehabilitation program. The Company will pay up to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits* for the program as set forth in a written agreement. The goal of the rehabilitation program will be to return an Insured Person to the workforce in a Reasonable Occupation for which he or she is reasonably suited considering the Covered Injury or Covered Illness sustained.

The Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other services. The other services and expenses that might be provided may include:

- coordination of physical rehabilitee and medical services;
- financial and business planning;
- vocational evaluation and transferable skills analysis;
- career counseling and retraining;
- labor market surveys and job placement services; and
- evaluation of necessary worksite modifications and adaptive equipment and may include work on a part time basis.

The Company can periodically review the program and an Insured Person's progress. The Company will continue to pay for the program as long as the Company determines that the program is helping an Insured Person return to the workforce.

An Insured Person's participation in a rehabilitation program will not, in and of itself, be considered a recovery from Total Disability or Partial Disability. Benefits for Weekly Total Disability or Partial Disability will continue as provided by the Policy while an Insured Person is actively participating in the program.

V.E. MENTAL STRESS MANAGEMENT BENEFIT
If an Insured Person suffers psychiatric or mental stress illness as a direct result of either being actively engaged in a single emergency incident or repeated active engagement in emergency incidents as a member of the Sponsoring Organization, the Company will pay a Mental Stress Management Benefit, in accordance with Sections III, IV and V of this Policy, subject to the Maximum Benefit Amount shown on the *Policy Schedule of Benefits.* The Insured Person must be receiving care by a Physician properly licensed to provide such care and the care must be appropriate for the condition causing the psychiatric or mental stress.

V.F. TRAUMATIC INCIDENT BENEFIT
The Company will pay the reasonable expenses for the services provided by a Traumatic Incident Stress Management Team if such services are requested and authorized by the Sponsoring Organization as a result of a Traumatic Incident. Expenses must be incurred within the time specified on the *Policy Schedule of Benefits* and are subject to the Traumatic Incident Aggregate Maximum Benefit Amount shown on the *Policy Schedule of Benefits*. The Traumatic Incident Aggregate Maximum Benefit Amount is the maximum that will be paid per Traumatic Incident, regardless of the number of Insured Persons treated.

V.G. HEALTH INSURANCE PREMIUM BENEFIT
If medical or health insurance premiums previously paid by the Insured Person’s employer have been discontinued as a result of an Insured Person's Covered Injury, Covered Illness, Total Disability or Partial Disability, disability benefits are paid under this Policy, and the Insured Person incurs out of pocket costs for those medical or health insurance premiums, the Company shall pay the amount the Insured Person’s employer previously paid for those medical or health insurance premiums. The Company will not pay more than the Maximum Benefit Amount shown on the *Policy Schedule of Benefits*.

This benefit is not payable if: 1) the Sponsoring Organization provides health insurance benefits for the Insured Person; or 2) the Insured Person provided and paid for their own health insurance benefits.

If the Insured Person was responsible for any portion of the medical or health insurance premium prior to the Covered Injury or Covered Illness, that portion of the medical or health insurance premium will not paid under this benefit.

CLAIMS PROVISIONS

CLAIM FORMS

Our administrator will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the Company received notice of claim, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made. The notice should include the Insured Person's name, the Sponsoring Organization's name and the Policy number. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

NOTICE OF CLAIM

A written incident report must be made to the Sponsoring Organization or Our administrator within 20 days, or as soon as reasonably possible, after the Covered Activity that may give rise to a loss under this Policy. Written notice of claim must be given to Our administrator within 20 days after the occurrence or commencement of the Insured Person's Covered Injury or Covered Illness or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company or to its designated authorized agent, with information sufficient to identify the Insured Person, is deemed notice to the Company. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form.

PROOF OF LOSS

In case of a claim for loss of time from disability, written proof of loss must be furnished within ninety (90) days of the date of such loss, or as soon as reasonably possible. Subsequent written proof of the continuance of such disability must be furnished at such time, in such manner and at such place as We may reasonably require.

For any loss other than a disability loss, written proof of loss must be furnished within ninety (90) days after such loss, or as soon as reasonably possible.

Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to furnish proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

PAYMENT OF CLAIMS

All benefits will be paid in United States currency. After We received written proof of loss of time due to disability, disability benefits payable under the Policy for loss of time will be paid monthly during the continuance of the period for which the Company is liable. Benefits for any other loss covered by this Policy will be paid not more than 60 (sixty) days after proof of loss is received. The balance of any unpaid benefits at the termination of the period for which the Company is liable will be paid as soon as possible after receipt of proof. Any payment We make in good faith will end Our liability to the extent of the payment of loss of life claims.

PAYMENT OF LOSS OF LIFE CLAIMS

Upon receipt of due written proof of death, unless otherwise indicated in a specific benefit, benefits for a loss of life claim will be paid to the beneficiary named by an Insured Person when he or she became covered under this Policy. An Insured Person has the right to change his or her beneficiary at any time by completing a form, approved by us, and submitting it to the Sponsoring Organization. The new beneficiary designation will be effective as of the date an Insured Person signed the required form. However, if We have taken any action or made any claim payment before the Sponsoring Organization receives an Insured Person's request to change his or her beneficiary, that change will not go into effect.

If an Insured Person does not name a beneficiary or names more than one beneficiary but does not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before an Insured Person, or the share of a beneficiary who is disqualified will pass to any surviving beneficiaries in the order designated by an Insured Person.

If an Insured Person does not name a beneficiary, or if a named beneficiary is disqualified, or if all named beneficiaries die before an Insured Person, We have the option of paying death benefits to an Insured Person's estate or surviving family members in the order listed below:

1. Spouse;
2. child or children, equally if living;
3. mother or father, equally or to the survivor; or
4. sisters or brothers, equally or to the survivor or survivors.

COOPERATION OF THE INSURED PERSON

Coverage under this Policy may terminate for any Insured Person who fails to cooperate with the Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

RIGHT TO OFFSET

If We determine that an overpayment of any benefit payable under this Policy has been made to an Insured Person due to fraud or any error We make in processing a claim, We reserve the right to:

1. offset said overpayment against any amounts otherwise payable to an Insured Person;
2. request reimbursement from an Insured Person for any overpayment made; or
3. bring legal action against an Insured Person to recover any overpayment.

RIGHT OF RECOVERY

If an Insured Person incurs expenses due to a Covered Injury or Covered Illness and the loss is caused by the act or omission of another person, an Insured Person may have a claim against the other person. If recovery is made, an Insured Person must repay us the recovery made from: (1) the other person; or (2) the other person's insurer. We will only have such right against excess funds and only if an Insured Person is made whole.

This right of recovery provision also applies when an Insured Person receives payment under an uninsured or underinsured motorist insurance policy or plan.

PHYSICAL EXAMINATION AND AUTOPSY

We, at Our expense, have the right to have an Insured Person examined as often as is reasonable while a claim is pending. We may also request to have an Insured Person examined, at Our expense, as proof of continued loss. We reserve the right to select the examiner. In the case of death, We may request to have an autopsy performed where it is not forbidden by law.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after the required proof of loss is furnished in accordance with the terms of this Policy. No action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Policy.

LEGAL EXPENSE

If, while receiving benefits under this Policy, an Insured Person incurs legal expenses for the denial or appeal of a Workers' Compensation claim related to Covered Injury or Covered Illness with the in-force Workers' Compensation carrier, We will reimburse an Insured Person for such expenses up to a maximum of $1,000. In no event will benefits be payable for liability, negligence or any other related lawsuit or action other than those specifically stated in this Policy. This benefit is payable for up to one (1) year following the date of the Covered Activity.

SUBROGATION

The Company has the right to recover all payments including future payments, which the Company has made, or will be obligated to pay in the future, to the Insured Person from anyone liable for the covered loss. If the Insured Person recovers from anyone liable for the covered loss, the Company will be reimbursed first from such recovery to the extent of the Company's payments to the Insured Person. The Insured Person agrees to assist the Company in preserving It's rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by the Company.

ARBITRATION

Any contest to a claim denial under this Policy will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the Insured Person or person claiming to be the beneficiary. The arbitrators(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the Insured Person or the person claiming to be the beneficiary is a resident of a state where the law does not allow binding arbitration in an insurance policy, but only if this Policy is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of any individual or class action lawsuit brought by the Insured Person, his or her legal representatives, or beneficiary.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when an Insured Person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Plan means any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules determine whether This Plan is a Primary Plan or Secondary Plan when the Insured Person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense means a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Insured Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Insured Person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an Allowable Expense.
The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If an Insured Person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If an Insured Person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If an Insured Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan means a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent means the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES
When an Insured Person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
   (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the Insured Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the Insured Person as a dependent is the Secondary plan. However, if the Insured Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Insured Person as a dependent; and primary to the Plan covering the Insured Person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Insured Person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:
(a) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
(b) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the Spouse of the Custodial Parent;
- The Plan covering the non-Custodial Parent; and then
- The Plan covering the Spouse of the non-Custodial Parent.

(c) For a Dependent Child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
(3) Active Employee or Retired or Laid-off Employee. The Plan that covers an Insured Person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same Insured Person as a retired or laid-off employee is the Secondary Plan. The same would hold true if an Insured Person is a dependent of an active employee and that same Insured Person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
(4) COBRA or State Continuation Coverage. If an Insured Person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Insured Person as an employee, member, subscriber or retiree or covering the Insured Person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
(5) Longer or Shorter Length of Coverage. The Plan that covered the Insured Person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the Insured Person the shorter period of time is the Secondary Plan.
(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on The Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
B. If an Insured Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must provide any facts needed to apply these rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

If the amount of the payments made under this Policy is more than should have been paid under this COB provision, The Company may recover the excess from one or more of the persons paid or for whom benefits have been paid; or from any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

PREMIUMS AND RENEWALS PROVISIONS

POLICY TERM AND RENEWAL

The first term of this Policy starts on the Effective Date shown on the *Policy Schedule of Benefits* and ends on the Expiration Date, also shown on the *Policy Schedule of Benefits*. The Policy will remain in effect for the duration of the Policy Term if the premium is paid according to the agreed upon terms. Later terms will be the periods for which the Policyholder pays renewal premiums agreed upon when due. All terms will begin and end at 12:01 A.M., Standard Time, at the location of the Policyholder.

The Company or the Policyholder may terminate this Policy on any anniversary of the first Renewal Date by giving the other party written notice at least thirty (30) days prior to that date. In that event, this Policy will terminate on the specified anniversary date at 12:01 A.M., Standard Time. Any premium rate guarantee will not affect the Company's or the Policyholder's right to terminate this Policy. Termination or nonrenewal will be without prejudice to the rights of any Insured Person with respect to any benefits payable under this Policy that began while this Policy was in force.

PREMIUMS

Premiums are paid at the Company's Home Office or to the Company's authorized agent. Any premium remitted by the Policyholder to its agent or broker will not be considered paid until it is received by us at Our office. If any premium is not paid when due, this Policy will be cancelled at the end of the last period for which premium was paid, except as provided in the Grace Period provision.

The first premium is due on the Effective Date shown on the *Policy Schedule of Benefits*. The renewal premium for each term will be due on the day the preceding term ends, subject to the Grace Period**,** unless the Policyholder and the Company agree to another mode of premium payment.

We may change the premium rate on any Renewal Date of this Policy or whenever the terms or conditions of the Policy are changed.

PREMIUM RATE CHANGES

The Company may change premium rates at the end of any Policy Term or any Premium Rate Guarantee Period with at least 31 days advance notice mailed to the last known address of the Policyholder. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

The Company may change the premium rate during a Policy Term or during any applicable Premium Rate Guarantee Period if any one of the following occurs:

1. the terms of this Policy change;
2. the number of Insured Persons or Eligible Persons for coverage increases or decreases by more than 25% since the later of the Policy Effective Date and the date of the last renewal of this Policy;
3. coverage is reinstated following failure to pay premium during the Grace Period;
4. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 25% or more the number of Insured Persons;
5. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this Policy.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

GRACE PERIOD

A grace period of thirty-one (31) days will be provided for the payment of any premium due after the first. During the grace period, the Policy shall continue in force, unless the Policyholder has given written notice of discontinuance in advance of the premium due date and in accordance with the Policy Term and Renewal provision.

Any renewal premium due must be paid, to Us, within the grace period following the renewal premium due date. If renewal premium is not paid within the thirty-one (31) day grace period, this Policy will automatically terminate at the end of the grace period. The Policyholder will be liable for the payment of a pro rata premium for the time the Policy was in force during the grace period.

PREMIUM AUDIT

The Company will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

REINSTATEMENT

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are a written application of the Policyholder satisfactory to the Company and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, including the application (if any) and any attached amendments, endorsements, riders and/or attached papers represents the entire contract between the Policyholder and the Company. All statements made by the officers or trustees of the Policyholder shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Person will be used in any contest under this Policy unless a copy of the statement is furnished to the Insured Person, or in the event of death or incapacity of the Insured Person, to the Insured Person's beneficiary or personal representative. No change in this Policy will be effective until approved by one of Our officers. This approval must be in writing and endorsed on or attached to this Policy. No agent can change this Policy or waive any of its provisions.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which is in conflict with the requirements of any state or federal law that applies to this Policy is changed to conform to the minimum requirements of such laws. Premiums may be changed, in accordance with the Premium Rate Change provision, to reflect these requirements.

WORKERS' COMPENSATION

This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law. This Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

ADDITION OF NEW INSURED PERSONS

All Insured Persons added to the Classes of Eligible Persons in the *Policy Schedule* are eligible for insurance under this Policy.

ASSIGNMENT

The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if the Company receives it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Injury or Covered Illness. Any other attempt to assign will be void.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

CLERICAL ERROR

An Insured Person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, the Company will adjust the premium fairly.

EXAMINATION OF THE POLICY

This Policy will be available for inspection at the Policyholder office during regular business hours.

INCONTESTABILITY

The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, misrepresentation or fraud.

Absent a showing of intentional fraud, no statement made by any Insured Person relating to insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime nor unless the statement is contained in a written instrument signed by the person making the statement.

However, the Company may contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

MISSTATEMENT OF FACT

If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

NONCOMPLIANCE WITH POLICY REQUIREMENTS

Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.

RECORDS

The Policyholder or its authorized Administrator will maintain the records of the Insured Person's insurance under this Policy. The Company will be permitted to examine the Policyholder's records relating to the insurance under this Policy at any reasonable time. The Policyholder is acting as an agent of the Insured Person for transactions relating to this insurance. The actions of the Policyholder will not be considered the actions of the Company.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

EFFECTIVE DATE FOR INDIVIDUALS

Insurance becomes effective for the Eligible Person on the latest of the following dates:

1. the Policy Effective Date; and
2. the date the person becomes eligible.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

EFFECTIVE DATE OF CHANGES

Any increase or decrease in the amount of insurance for the Insured Person resulting from a change in benefits provided by this Policy or a change in the Insured Person's covered class will take effect on the date of such change.

ELIGIBILITY

A person is eligible for insurance under this Policy when he or she meets the definition of Eligible Person shown in the *Policy Schedule of Benefits*. An Eligible Person may be insured under only one covered class, even though he or she may be eligible under more than one covered class.

TERMINATION OF INSURANCE

Insurance for the Insured Person will end on the earliest of:

1. the date the person is no longer in an Eligible Class; and
2. the date this Policy ends.

Termination does not affect a claim for a covered loss due to a Covered Injury or Covered Illness that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable benefit limit or maximums, as shown on the *Policy Schedule of Benefits*, have been paid.

Underwritten by:
AXIS Insurance Company
111 South Wacker Drive, Suite 3500
Chicago, Illinois 60606
(A Stock Company)

Administrative Office:
1 University Square Drive, Suite 200
Princeton, NJ 08540

Policyholder: Anytown USA Fire Protection District
Policy Number: PRCO-XXXXX-XXXXXXX
Effective Date of this Rider: 03/01/2023

Career Or Part-Time Personnel Rider

This Rider is attached to and made part of the Policy as of the Effective Date shown above. It applies only with respect to Covered Injuries or Covered Illnesses that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider. See the *Policy Schedule of Benefits* of the Policy for the applicability of this Rider with respect to each class of Insured Persons.

Section III: INCOME PROTECTION BENEFITS

For Class II only, the following statement is added to the Limitations of the Income Protection Benefit section of the Policy:

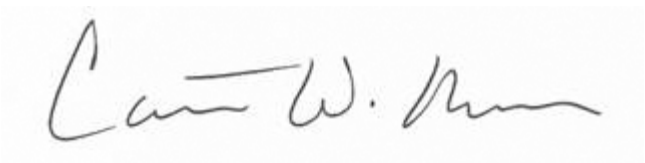
If an Insured Person is approved for disability retirement or otherwise retires, all eligibility for Total Disability or Partial Disability terminates on the effective date of such retirement.

TERMINATION OF THIS RIDER

This Rider will end on the earlier of:
1. the date We receive written notice from the Policyholder to cancel this Rider; and
2. the date the Policy terminates.

The President and Secretary witness this Rider:

Secretary



President

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AXIS Insurance Company values its relationship with you. Protecting the privacy of the information we have about you is of great importance to us. We want you to understand how we protect the confidentially of information as well as how and why we use and disclose it. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to this information. "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare.

This privacy policy applies to policies underwritten by AXIS Insurance Company. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice. We reserve the right to change the terms of this notice, and should that occur, we will provide you with a copy of the new notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION
We use and disclose your Protected Health Information (PHI) for the purposes of your treatment, for payment and for health care operations. Not every use or disclosure in a category is listed. However all of the ways that we may use or disclose PHI will fall within one of these categories.

Your Authorization: Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing use or disclosure. You may take away this authorization at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

For Payment: We use and disclose PHI as necessary for payment purposes. For example, we may use your PHI to process a claim or may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and disclose PHI for our health care operations such as customer service, premium rating, fraud and abuse prevention and detection, and other functions related to your health policy. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To Others: You may authorize us in writing to give your PHI to someone else for any reason. Also, if you are present, and provide authorization, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are unavailable, incapacitated, or facing an emergency medical situation, we may share limited PHI with a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also use or disclose your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared for any purpose as required by law.

We may share PHI with the sponsor of the plan or use in the administration of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

YOUR HIPAA PRIVACY RIGHTS

Access to Your PHI

You have the right to obtain a copy and inspect specific items of your PHI, such as your policy or claim information, for as long as we maintain it. We may deny your request to access certain PHI, as permitted or required by law. We may require your request for access in writing. Your request for access should contain as much detail as possible regarding the PHI you wish to review. We may charge a reasonable fee for access to your PHI.

Amendments to Your PHI

You have the right to request that the PHI we maintain about you be amended or corrected if you believe it is incorrect. We are not legally obligated to make all requested amendments but will give each request appropriate consideration. Requests for amendment must be in writing and must state the reasons for the amendment request.

Accounting for Disclosures of Your PHI

You have the right to request an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. Requests must be made in writing. We are not legally obligated to provide an accounting of every disclosure but will give each request appropriate consideration. The accounting will not include disclosures made prior to June 1, 2011.

Restrictions on Uses and Disclosures of Your PHI

You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. We are not legally required to agree to your restriction request but will give each request appropriate consideration.

Confidential Communication of PHI

You have the right to request to receive communications from us regarding your PHI by another method of contact or at an alternative address. We will accommodate reasonable requests, which must clearly state that disclosure of all or part of the information could endanger your health or safety.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services in Washington, D.C. We will not take action against you for filing a complaint.

Contact Information

If you have questions or need further assistance regarding this Notice, or wish to exercise any of the abovementioned rights, you may write to us at

Administrative Address:
AXIS Insurance Company
1 University Square Drive, Suite 200
Princeton, NJ 08540
888.870.AXIS (2947)
General questions - please send to USSales.AccHealth@axiscapital.com

Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective June 1, 2011

OFAC NOTICE

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit AXIS Insurance Company from providing insurance, including, but not limited to, the payment of claims.

Payment of claims under any insurance policy issued shall only be made in full compliance with all United States economic or trade and sanction laws or regulation, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

Table of Contents

SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, PLEASE READ ALL THE POLICY PROVISIONS CAREFULLY.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the Conditions of Coverage and Description of Benefits sections for full details.

Eligible Persons: An Eligible Person is an individual who meets all of the requirements of one of the covered classes shown below:

Class A	**Principal Sum**
All Active Members of the Policyholder	$10,000

CONDITIONS OF COVERAGE

The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages:

Class A

24 HOUR BUSINESS AND PLEASURE COVERAGE

BENEFITS

Aggregate Limit of Indemnity

Applies to:	**Benefit Amount**
Accidental Death and Dismemberment	Ten times the Class A Principal Sum, not to exceed $1,000,000

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses, Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident that occurs under one of the Conditions of Coverage, as specified above. This Aggregate Limit of Indemnity is payable only once, should more than one Condition of Coverage apply, We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss must occur within	365 days of the Covered Accident (Loss period does not apply to Loss of Life)

Covered Loss	**Benefit Amount**
Loss of Life	100% of the Principal Sum
Loss of or Loss of Use of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of Speech and Hearing in Both Ears	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Loss of or Loss of Use of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing in Both Ears	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Thumb and Index Finger of the same Hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all Toes of the Same Foot	25% of the Principal Sum
Loss of Thumb	25% of the Principal Sum
Loss of Index Finger	25% of the Principal Sum
Loss of Any Joint on Either Hand	6.25% of the Principal Sum
Loss of 2nd, 3rd, or 4th Finger of Either Hand	12.5% of the Principal Sum
Loss of Large Toe of Either Foot	5% of the Principal Sum
Loss of a Joint of a Toe	1% of the Principal Sum
Exposure and Disappearance	**Included**

PREMIUM RATE TABLE

It is hereby agreed and understood that the premium amounts, and the manner in which premiums are due and payable, are as follows:

Annual Premium $10,644

Premium Due Date Policy Effective Date

The initial premium rate guarantee and any premium rate guarantee applicable to renewal are subject to the Cancellation and Premium Rate Change sections of the Administrative Provisions of this Policy.

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Accident or Accidental means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.

Aircraft means a vehicle which:
1. has a valid Airworthiness Certificate; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Airworthiness Certificate means a “Standard" Airworthiness Certificate issued by the Federal Aviation Agency of the United States of America or its equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.

Calendar Year means January 1st through December 31st of any year.

Common Carrier or Public Conveyance means:
1. a Conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.

Conveyance means a motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority.

Covered Accident means an Accident that results in a Covered Loss during the Policy Term.

Covered Activity or Covered Activities means any activity that is shown in the *Schedule of Benefits* and:
1. takes place under one of the Conditions of Coverage specified in the *Schedule of Benefits;* and
2. is sponsored, organized, scheduled or otherwise provided by the Policyholder.

Covered Expenses means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.

Covered Injury means Accidental bodily injury: (1) which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force; (2) which results directly and independently from all other causes from a Covered Accident; and (3) which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Covered Loss means a loss which meets the requisites of one or more benefits, and results from a Covered Accident, Covered Injury or Covered Activity.

Eligible Person means an individual as defined in the *Schedule of Benefits.*

He, His, Him refers to any individual, male or female.

Hospital means an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics; or
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Insured Person incurs an expense.

Hospital Confined, Hospital Stay or Confined to a Hospital means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least 30 days.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, domestic partner, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Inpatient means confined overnight as a registered bed patient in a Hospital or other medical facility where at least one day's room and board is charged. The confinement must be on the advice of a Physician.

Insured Person means an Eligible Person, as defined in the *Schedule of Benefits*, for whom required premium has been paid when due and for whom coverage under this Policy remains in force.

Medically Necessary means medical services that: (1) are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) are ordered by a Physician and performed under His care, supervision or order.

Nurse means a licensed graduate Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) who is not:

1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household; or
4. a person employed or retained by the Policyholder.

Outpatient means an Insured Person who is a patient and is not hospitalized overnight but who visits a Hospital, clinic, or associated facility for diagnosis or treatment.

Physician	means a licensed health care provider practicing within the scope of his license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not: 1 the Insured Person; 2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse; 3. a person living in the Insured Person's household; 4. a person employed or retained by the Policyholder; or 5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.
Policyholder	means the entity, named on this Policy's face page, to which the Company issues this Policy.
Policy Term	means the time period defined for the Policyholder shown on this Policy's face page.
Private Passenger Automobile	means a validly registered, four wheel private passenger car, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxi cab, bus or other Public Conveyance will not be considered a Private Passenger Automobile.
Scheduled Airlines or Aircraft	means any carrier holding a certificate, license or similar authorization for civilian scheduled air transport issued by the country of the Aircraft's registry, and which, in accordance with that authorization flies, maintains and publishes schedules and tariffs for regular passenger service between named cities at regular and specified times, but only if the Aircraft is then used for any regular or chartered flight operated by such carrier.
Spouse	means the Insured Person's lawful spouse.
Usual and Customary Charge	means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.
We, Us, Our	means AXIS Insurance Company.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligibility

A person is eligible for insurance under this Policy when He meets the definition of Eligible Person shown in the *Schedule of Benefits.* An Eligible Person may be insured under only one covered class, even though He may be eligible under more than one covered class.

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Insured Person resulting from a change in benefits provided by this Policy or a change in the Insured Person's covered class will take effect on the date of such changes.

Policy Effective Date

The Company agrees to provide Accident insurance benefits described in this Policy in consideration of the Policyholder's application and payment of the Premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page.

Termination of Insurance

Insurance for the Insured Person will end on the earliest of:

1. the date the person is no longer in an Eligible Class;
2. the end of the period for which the last premium is made; or
3. the date this Policy ends.

Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable benefit limit or maximums, as shown in the *Schedule of Benefits*, have been paid.

OFAC NOTICE

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit AXIS Insurance Company from providing insurance, including, but not limited to, the payment of claims.

Payment of claims under any insurance policy issued shall only be made in full compliance with all United States economic or trade and sanction laws or regulation, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as:
   a. a fare-paying passenger on a regularly scheduled commercial or charter airline;
   b. a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight; or
6. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
10. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
11. benefits will not be paid for services or treatment rendered by any person who is:
    a. employed or retained by the Policyholder;
    b. living in the Insured Person's household;
    c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
    d. the Insured Person.

CLAIM PROVISIONS

Beneficiary

If more than one person is named as beneficiary, the interests of each will be equal unless the Insured Person has specified otherwise. The share of any beneficiary who does not survive the Insured Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Insured Person dies while benefits are payable to Him, the Company may make direct payment to the first surviving class of the following classes of persons:

1. Spouse;
2. child or children;
3. parents;
4. siblings; or
5. estate of the Insured Person.

Claim Forms

The Company or its designated authorized agent will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the Company received notice of claim, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made. The notice should include the Insured Person's name, the Policyholder's name and the Policy Number. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

Notice of Claim

Written notice of claim must be given to the Company or its designated authorized agent within 30 days after the occurrence or commencement of the Insured Person's Covered Loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company or its designated authorized agent, with information sufficient to identify the Insured Person, is deemed notice to the Company. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form.

Payment of Claims

All benefits will be paid in United States currency. Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person's beneficiary as described in the Beneficiary Provision and these Claim Provisions.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments due have been made, the amount still payable will be paid to His beneficiary as described in the Beneficiary Provision.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to a parent, guardian, or other person actually supporting Him. If the payee has no legal guardian for His property, a payment not exceeding $1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges liability to the extent of the payment made.

Time of Payment of Claims

Benefits payable under the Policy for any loss other than loss for which

the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Conditional Claim Payment

If the Insured Person incurs expenses for Covered Injuries and in Our opinion a third party may be liable, the Company will pay benefits if the Insured Person first agrees in writing to refund the lesser of:

1. the amount the Company actually paid for such expenses; and
2. the amount actually received from the third party, regardless of whether the amount is for such expenses, and the third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, if the third party's liability is satisfied in an amount less than the benefits paid under this Policy, the Company will pay the difference.

Legal Actions

No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought after expiry of the applicable statute of limitations from the time proof of loss is required to be furnished under this Policy.

Physical Examination And Autopsy

The Company, at its own expense, has the right and opportunity to examine the Insured Person when and as often as the Company may reasonably require while a claim is pending and to make an autopsy in case of death, where it is not prohibited by law.

Proof of Loss

Written proof of loss must be furnished to the Company within 90 days after the date of the Covered Loss. In the case of a claim for loss of time for disability, written proof of such loss must be furnished to the Company within 90 days after the commencement of the period for which the Company is liable. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as may reasonably be required. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to furnish proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

Subrogation

The Company has the right to recover all payments including future payments, which the Company has made, or will be obligated to pay in the future, to the Insured Person from anyone liable for the Covered Loss. If the Insured Person recovers from anyone liable for the Covered Loss, the Company will be reimbursed first from such recovery to the extent of the Company's payments to the Insured Person. The Insured Person agrees to assist the Company in preserving its rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by the Company.

ADMINISTRATIVE PROVISIONS

Cancellation

The Company or the Policyholder may cancel this Policy after the first year or Policy Term or as of any Premium Due Date, by giving the other party 31 days advance written or authorized electronic notice. Any premium rate guarantee will not affect the Company's or the Policyholder's right to cancel this Policy.

If a premium is not paid when due, the Company will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the Premium Rate Table.

Cancellation does not affect a claim for a Covered Loss when the Covered Accident occurs before the cancellation date.

Grace Period

A grace period of 31 days will be provided for the payment of any premium due after the first Premium Due Date. During the grace period, the Policy shall continue in force, unless the Policyholder has given written notice of discontinuance in advance of the Premium Due Date and in accordance with the terms of this Policy. If the required premium is not paid during the grace period, coverage will terminate on the last day of the grace period. The Policyholder will be liable for the payment of a pro rata premium for the time the Policy was in force during the grace period.

Premiums

Premium rates are expressed in, and premiums are payable in, United States currency. The Company will provide notifications of premiums due or premium changes, to the most current address in Our files, to the Policyholder.

Premium Payment

The total premium paid by the Policyholder is the sum of premiums for all Insured Persons. The initial premium is due on the Policy Effective Date and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the Premium Rate Table, unless the Policyholder and the Company agree to another mode of premium payment. Premiums are paid at the Company's Home Office or to the Company's authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premium, except as provided in any applicable Grace Period section.

Premium Rate Changes

The Company may change premium rates at the end of any Policy Term or any premium rate guarantee period with at least 31 days advance notice to the last known address of the Policyholder. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

The Company may change the premium rate during a Policy Term or during any applicable premium rate guarantee period if any one of the following occurs:

1. the terms of this Policy change;
2. coverage is reinstated following failure to pay premium during the Grace Period; or
3. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this Policy.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit

The Company will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

Reinstatement

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are a written application of the Policyholder satisfactory to the Company and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

GENERAL PROVISIONS

Addition of New Insured Persons

All Insured Persons added to the Classes of Eligible Persons in the *Schedule of Benefits* are eligible for insurance under this Policy.

Assignment

The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if the Company receives it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

Certificates

Where required by law, the Company will provide a certificate of insurance for delivery to the Insured Person. Each certificate will set forth a statement as to the insurance coverage to which the Insured Person is entitled, and to whom the insurance benefits are payable, and a statement as to any family member, Spouse or dependent's coverage. If family members or dependents are included in the coverage, the insurer need only issue one certificate to each family unit.

Clerical Error

A person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, the Company will adjust the premium fairly.

Conformity with Statutes

Any provision in this Policy that is in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Entire Contract; Changes

The Policy and any attached papers make up the entire contract between the Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any Insured Person will be considered representations and not warranties. No written statement made by an Insured Person will be used in any contest unless a copy of the statement is furnished to the Insured Person or, in the event of the death or incapacity of the Insured Person, to His beneficiary or personal representative.

No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Examination of the Policy

This Policy will be available for inspection at the Policyholder's office during regular business hours.

Incontestability

The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, misrepresentation or fraud.

However, the Company may contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

Misstatement of Fact

If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Noncompliance with Policy Requirements

Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.

Policy Changes

No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. The Company may agree with the Policyholder to modify a plan of benefits without the Insured Person's consent.

Records

The Policyholder or its authorized Administrator will maintain the records of the Insured Person's insurance under this Policy. The Company will be permitted to examine the Policyholder's records relating to the insurance under this Policy at any reasonable time. The Policyholder is acting as an agent of the Insured Person for transactions relating to this insurance. The actions of the Policyholder will not be considered the actions of the Company.

Reporting Requirements

The Policyholder or its authorized agent must report all of the following to the Company by the Premium Due Date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated; and
4. additional information required by the Company.

The Company may, at the Company's sole discretion, waive reporting of any information specified above.

Workers' Compensation

This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

CONDITIONS OF COVERAGE

This Section describes the Conditions of Coverage under which benefits provided by this Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the Common Exclusions sections in order to understand all of the terms, conditions and limitations of coverage.

24-HOUR BUSINESS AND PLEASURE COVERAGE

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs any time while insured by this Policy including riding in or entering an Aircraft.

Exclusions

Exclusions that apply to this Condition of Coverage are in the Common Exclusions Section.

DESCRIPTION OF BENEFITS

This Description of Benefits Section describes the Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits.* Please read these and the Common Exclusions section in order to understand all of the terms, conditions and limitations applicable to these Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Losses

The Company will pay the Benefit Amount for any one of the Covered Losses listed in the *Schedule of Benefits,* subject to all applicable conditions and exclusions*,* if the Insured Person suffers a loss as a result of a Covered Injury within the applicable time period specified in the *Schedule of Benefits.*

If the Insured Person sustains more than one Covered Loss as a result of the same Covered Accident, the Company will pay the Benefit Amount for the Covered Loss for which the largest benefit is payable.

Exposure and Disappearance

If by reason of an Accident occurring while an Insured Person's coverage is in force under this Policy, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a Covered Loss for which an Accidental Death or Accidental Dismemberment Benefit is otherwise payable under the Policy, the Covered Loss will be covered under the terms of this Policy.

If the body of an Insured Person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a Conveyance in which the Insured Person was an occupant while covered under this Policy, then it will be deemed, subject to all other terms and provisions of this Policy, that the Insured Person has suffered an Accidental Death that would have been payable under the Policy.

Definitions

For purposes of this Benefit:

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Severance means complete separation and dismemberment of the part from the body.

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

Underwritten by:
AXIS INSURANCE COMPANY
111 South Wacker Drive, Suite 3500
Chicago, IL 60606
(A Stock Company)

Administrative Office:
1 University Square Drive
Suite 200
Princeton, NJ 08540

Policyholder: Anytown USA Fire Protection District

Policy Number: CRTI-XXXXX-XXXXXXX

Effective Date of this Rider: February 15, 2023

This Rider is attached to and made part of the Policy as of the Effective Date shown above. It is subject to all of the provisions, limitations and exclusions of the Policy except as specifically modified herein.

THIS IS LIMITED BENEFIT COVERAGE.
FOR CRITICAL ILLNESS BENEFITS TO BE PAYABLE. THE INSURED PERSON MUST SURVIVE FOR 30 DAYS AFTER DIAGNOSIS OF THE CRITICAL ILLNESS.
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

RIDER SCHEDULE

CRITICAL ILLNESS BENEFITS

Face Amount

Insured Person ……$ 10,000

Critical Illness	Benefit Amount
Heart Attack	
First Diagnosis Benefit	100% of Face Amount
Invasive Cancer	
First Diagnosis Benefit	100% of Face Amount
In-Situ Cancer	
First Diagnosis Benefit	100% of Face Amount
Kidney (Renal) Failure	
First Diagnosis Benefit	100% of Face Amount
Stroke	
First Diagnosis Benefit	100% of Face Amount

RIDER DEFINITIONS

Critical Illness – means any of the following illnesses: Heart Attack, Invasive Cancer, In-Situ Cancer, Kidney (Renal) Failure, Stroke, as each is defined in this Rider.

Diagnosed/Diagnosis – means a definitive and unequivocal diagnosis made by a Physician who specializes in the condition for which benefits are being claimed: (1) based upon the use of clinical and/or laboratory investigations as supported by the Insured Person's medical records; and (2) meeting any Diagnostic Requirements set forth in this Rider for the particular Critical Illness being diagnosed.

Eligible Class means the classification(s) of Eligible Persons as shown in the Schedule of Benefits.

Rider Schedule means the schedule found in the beginning of this Rider.

Schedule of Benefits means the schedule provided in the Policy.

Sickness means an illness or disease which requires treatment by a Physician.

Other definitions that apply to this Rider are in the *General Definitions* section of the Policy.

EFFECTIVE AND TERMINATION DATES

Insured Person's Effective Date. Coverage for a person in an Eligible Class as shown in the Schedule of Benefits will become effective as follows.

No enrollment is required if a person is not required to contribute towards the cost of coverage. Such person's coverage will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. the date the person becomes a member of an Eligible Class;
3. the date for which the first premium for the person's coverage is paid;
4. the Effective Date of this Rider as shown above.

Insured Person's Termination Date. An Insured Person's coverage ends on the earliest of: (1) the date the Policy is terminated; (2) the end of the Grace Period if premiums are not paid when due; (3) the next anniversary date on or following the date the Insured Person attains age 75; (4) the date the Insured Person requests, in writing, that his or her coverage be terminated; (5) the date the Insured Person ceases to be a member of an Eligible Class.

Termination of coverage will not affect a claim for a Critical Illness benefit or Covered Loss that occurred while the Insured's coverage was in force under the Policy.

If an Insured Person's coverage under the Policy ends for any reason, except nonpayment of premium, while the Insured Person is hospitalized, coverage shall continue for a period of ten consecutive days during a single period of continuous hospitalization.

DESCRIPTION OF BENEFITS

CRITICAL ILLNESS DIAGNOSIS BENEFITS

If, while coverage under the Policy is in force, an Insured Person is Diagnosed with a Critical Illness by a Physician, the Company will pay the Benefit Amount shown in the Rider Schedule, subject to the Diagnostic Requirements and Benefit Payment Conditions listed below.

Once a Critical Illness has been Diagnosed and a First Diagnosis Benefit has become payable to an Insured Person for that Critical Illness, no benefits are payable for that Insured Person with respect to the Diagnosis of any other Critical Illness.

Benefit Payment Conditions
Payment of benefits upon the first Diagnosis of the Critical Illnesses listed below are subject to the following:

1. the Diagnosis is made while the Insured Person's coverage is in force under the Policy;
2. payment is not precluded by any general or specific exclusion or limitation set forth in this Rider or any failure to meet any condition precedent set out below;
3. the Insured Person survives for at least 30 days after the date the Critical Illness is Diagnosed.

Diagnostic requirements

- **All Critical Illnesses** – The Company reserves the right to have any Critical Illness Diagnosis reviewed by a Physician of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, the Company shall have the right to request an examination of either the Insured Person or the evidence used in arriving at such Diagnosis by an independently acknowledged expert selected by the Company in the applicable field of medicine.

  The opinion of such expert as to such Diagnosis shall be binding on both the Insured Person and the Company.

Heart Attack

First Diagnosis If an Insured Person is Diagnosed as having suffered a Heart Attack more than 90 days after the Effective Date of this Rider, the Company will pay the Benefit Amount shown for Heart Attack in the Rider Schedule.

Definitions For purposes of this benefit:

Heart Attack means the death of a portion of the heart muscle as a result of inadequate cardiac blood supply to the relevant area.

Diagnostic requirements
The Diagnosis of Heart Attack must be based on an event which contains all of the following criteria: (1) associated new electrocardiographic (EKG) changes which support the Diagnosis; (2) concurrent diagnostic elevation of cardiac enzymes above normal levels; and (3) confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Invasive Cancer

First Diagnosis If an Insured Person is first Diagnosed with Invasive Cancer more than 90 days after the Effective Date of this Rider, the Company will pay the Benefit Amount for Invasive Cancer shown in the Rider Schedule.

Definitions For purposes of this benefit:

Invasive Cancer – means a disease which is manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. For the purposes of this definition, it does NOT mean the following:

1. pre-malignant lesions, benign tumors or polyps;
2. leukoplakia;
3. hyperplasia;
4. carcinoid;
5. any tumors in the presence of any human immuno-deficiency virus (HIV);
6. polycythemia;
7. stage 1 Hodgkin's disease;
8. stage A prostate cancer;
9. Duke's stage A colon cancer;
10. intraductal non-invasive breast cancer;

11. stage 0 or 1 transitional cell carcinoma of urinary bladder; and
12. any skin cancer other than malignant melanoma with a depth of 1mm or deeper or greater than Clark level 2.
13. $T_1N_0M_0$ (TNM Classification System) papillary carcinoma of the thyroid less than 1 cm in diameter;
14. chronic Lymphocytic Leukemia RAI stage 0;
15. In-Situ Cancer.

In-Situ Cancer – means carcinoma cancer that is confined to the organ where it first developed and has not spread to other parts of the body. In-Situ Cancer includes Stage 1 Hodgkin's disease.

Diagnostic requirements
Invasive Cancer must be positively Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology, upon the basis of a microscopic examination of fixed tissues, or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard.

In-Situ Cancer

First Diagnosis If an Insured Person is first Diagnosed with In-Situ Cancer more than 90 days after the Effective Date of this Rider, the Company will pay the Benefit Amount for In-Situ Cancer shown in the Rider Schedule.

Definitions For purposes of this benefit:

In-Situ Cancer – means carcinoma cancer that is confined to the organ where it first developed and has not spread to other parts of the body. In-Situ Cancer includes Stage 1 Hodgkin's disease.

Diagnostic requirements
In-Situ Cancer must be positively Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology, upon the basis of a microscopic examination of fixed tissues, or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard.

Kidney (Renal) Failure

First Diagnosis If an Insured Person is first Diagnosed with Kidney (Renal) Failure more than 90 days after the Effective Date of this Rider, the Company will pay the Benefit Amount for Kidney (Renal) Failure shown in the Rider Schedule.

Definitions For purposes of this benefit:

Kidney (Renal) Failure means end stage failure which: (1) presents as a chronic irreversible failure of at least one of the kidneys to function; and (2) necessitates treatment by regular renal dialysis or kidney transplant.

Diagnostic requirements
The Diagnosis of Kidney (Renal) Failure must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.

Stroke

First Diagnosis If an Insured Person is first Diagnosed with having suffered a Stroke more than 90 days after the Effective Date of this Rider, the Company will pay the Benefit Amount for Stroke shown in the Rider Schedule.

Definitions For purposes of this benefit:

Stroke – means: (1) a cerebrovascular incident caused by infarction of brain tissue, cerebral hemorrhage, thrombosis, or embolization from an extra-cranial source lasting more than 24 hours; and (2) producing measurable neurological deficit persisting for at least 30 days following the occurrence of the Stroke.

The following are not considered Strokes:

1. Transient Ischemic Attacks (TIAs)
2. Vertebro-Basilar Insufficiency
3. Incidental findings on imaging studies

Transient Ischemic Attack (TIA) means a neurological condition or event with the signs and symptoms of a stroke, but which disappear within a short period of time with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.

Diagnostic requirements

The Diagnosis of Stroke must be made by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.

LIMITATIONS AND EXCLUSIONS

Pre-Existing Condition Limitation

Benefits provided by this Rider are not payable in connection with a Pre-Existing Condition for a period ending the earlier of: (1) the end of 12 consecutive months commencing on or after the date the Insured Person has been enrolled for coverage under this Rider during all of which the Insured Person has received no medical advice or treatment in connection with the Pre-Existing Condition; and (2) the end of the 1-year period commencing on the effective date of the Insured Person's coverage under this Rider. A Critical Illness resulting from a Pre-Existing Condition commencing thereafter will be covered unless otherwise excluded by this Policy.

A Pre-Existing Condition means a disease or physical condition cauded by illness or injury for which medical advice or treatment has been received 90 days to the effective date of the Insured Person's coverage under the Policy.

Exclusions

This Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

(a) the Insured Person's suicide, or intentional self-inflicted Injury or Sickness, while sane or insane.
(b) the Insured Person's being under the influence of an excitant, depressant, hallucinogen, narcotic, other drug; or intoxicant including those taken as prescribed by a Physician.
(c) the Insured Person's commission of or attempt to commit an assault or felony.
(d) the Insured Person's engaging in an illegal activity or occupation.
(e) the Insured Person's voluntary participation in a riot.
(f) any illness, loss or condition specifically excluded from the definition of any Critical Illness.
(g) war, whether declared or not, however this does not include loss due to terrorism.

The President and Secretary witness this Rider:

Secretary

President

SUMMARY OF THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of Pennsylvania who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable. Insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, Pennsylvania 19087
(610) 975-0572

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of the law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the Pennsylvania Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or annuity or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FOR COVERAGE

Persons holding such policies or contracts are not protected by the Association if:

- they are not residents of the State of Pennsylvania, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Pennsylvania at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation (e.g., a blue cross or blue shield plan), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, association or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields that exceed an average rate;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- annuity contracts or group annuity certificates used by nonprofit educational institutions and their employees;
- policies, contracts, certificated or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

LIMITS ON AMOUNTS OF COVERAGE

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the overall $300,000 limit, the Association will pay up to $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender or withdrawal values. For annuities, the Association will pay up to $300,000 in annuity benefits or $100,000 in net cash surrender or withdrawal benefits. For health insurance, the Association will pay up to $100,000, including any net cash surrender or withdrawal benefits.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AXIS Insurance Company values its relationship with you. Protecting the privacy of the information we have about you is of great importance to us. We want you to understand how we protect the confidentially of information as well as how and why we use and disclose it. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to this information. "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare.

This privacy policy applies to policies underwritten by AXIS Insurance Company. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice. We reserve the right to change the terms of this notice, and should that occur, we will provide you with a copy of the new notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose your Protected Health Information (PHI) for the purposes of your treatment, for payment and for health care operations. Not every use or disclosure in a category is listed. However all of the ways that we may use or disclose PHI will fall within one of these categories.

Your Authorization: Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing use or disclosure. You may take away this authorization at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

For Payment: We use and disclose PHI as necessary for payment purposes. For example, we may use your PHI to process a claim or may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and disclose PHI for our health care operations such as customer service, premium rating, fraud and abuse prevention and detection, and other functions related to your health policy. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To Others: You may authorize us in writing to give your PHI to someone else for any reason. Also, if you are present, and provide authorization, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are unavailable, incapacitated, or facing an emergency medical situation, we may share limited PHI with a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also use or disclose your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared for any purpose as required by law.

We may share PHI with the sponsor of the plan or use in the administration of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

YOUR HIPAA PRIVACY RIGHTS

Access to Your PHI

You have the right to obtain a copy and inspect specific items of your PHI, such as your policy or claim information, for as long as we maintain it. We may deny your request to access certain PHI, as permitted or required by law. We may require your request for access in writing. Your request for access should contain as much detail as possible regarding the PHI you wish to review. We may charge a reasonable fee for access to your PHI.

Amendments to Your PHI

You have the right to request that the PHI we maintain about you be amended or corrected if you believe it is incorrect. We are not legally obligated to make all requested amendments but will give each request appropriate consideration. Requests for amendment must be in writing and must state the reasons for the amendment request.

Accounting for Disclosures of Your PHI

You have the right to request an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. Requests must be made in writing. We are not legally obligated to provide an accounting of every disclosure but will give each request appropriate consideration. The accounting will not include disclosures made prior to June 1, 2011.

Restrictions on Uses and Disclosures of Your PHI

You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. We are not legally required to agree to your restriction request but will give each request appropriate consideration.

Confidential Communication of PHI

You have the right to request to receive communications from us regarding your PHI by another method of contact or at an alternative address. We will accommodate reasonable requests, which must clearly state that disclosure of all or part of the information could endanger your health or safety.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services in Washington, D.C. We will not take action against you for filing a complaint.

Contact Information

If you have questions or need further assistance regarding this Notice, or wish to exercise any of the abovementioned rights, you may write to us at

Administrative Address:
AXIS Insurance Company
1 University Square Drive, Suite 200
Princeton, NJ 08540
888.870.AXIS (2947)
General questions - please send to USSales.AccHealth@axiscapital.com

Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective June 1, 2011

OFAC NOTICE

Payment of claims under any insurance policy issued shall only be made in full compliance with all United States economic or trade and sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").