FLORIDA

GAP AME SM

Gap AME Plan℠
Member Driven Value.
Group Insurance Certificates

*These Group Insurance Certificates are for the Gap AME Plan℠ **purchased on or after 090717**. If you purchased the Gap AME Plan℠ **prior to 090717**, your group insurance certificates may be different. You can call your personal member concierge at 866.438.4274 to get your correct certificates.*

Catlin Insurance Company, Inc.
Statutory Home Office: 1330 Post Oak Boulevard, Suite 2325, Houston, TX 77056
Administrative Office: 3340 Peachtree Road N.E., Suite 2950, Atlanta, GA 30326
A Stock Company

Catlin Insurance Company, Inc.
Statutory Home Office: 2800 Post Oak Blvd., Suite 4050, Houston, TX 77056
Administrative Office: 3340 Peachtree Road N.E., Suite 2950, Atlanta, GA 30326
A Stock Insurance Company

GROUP ACCIDENT CERTIFICATE

THIS CERTIFICATE IS A QUALIFIED GROUP ACCIDENT INSURANCE CONTRACT

Certifies that the Insured is covered under the Policy issued to the Policyholder.

"We", "Our" and "Us" are used to refer to the Catlin Insurance Company, Inc.

This certificate is not the Policy. It is evidence of the Member's coverage under the Policy. Coverage is subject to the Policy provisions. The Policy was issued to the Policyholder. The Member may inspect the Policy at the Policyholder's office during normal business hours.

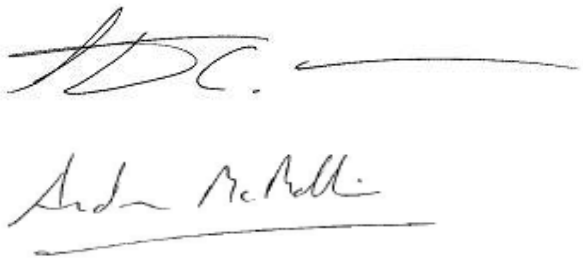
CAUTION: If the Member as misstated any fact, all amounts payable under the Policy will be such as the premium paid would have purchased had such fact been correctly stated.

A copy of the application is attached to this certificate. The best time to clear up any questions is now, before a claim arises. If you have any questions contact Us at this address:

Catlin Insurance Company, Inc.
c/o Health Special Risk, Inc.
P.O. Box 117086
Carrollton, Texas 75011

This Certificate describes the terms and conditions of insurance. The laws of the State of Issue govern the Policy.

Signed for Catlin Insurance Company, Inc. at its Home Office, 2800 Post Oak Boulevard, Suite 4050, Houston, Texas 77056.



Secretary President

Countersigned_____
Where Required By Law

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION.

THIS CERTIFICATE CONTAINS AN EXCESS PROVISION.

To present inquiries or obtain information about coverage and to provide assistance in resolving complaints, please call 1-877-228-5468.

EFFECTIVE DATE AND TERM

The Policy starts on the Policy Effective Date. The Covered Person's coverage starts on the Covered Person's Effective Date stated in the Certificate Identification. It stays in-force for the period for which the Covered Person's premium has been paid.

The Covered Person's coverage may be continued in force, as provided in the Continuation of Insurance clause. If the Policy is not renewed or the Covered Person is no longer eligible for coverage the Covered Person's coverage will cease at the termination date.

CERTIFICATE IDENTIFICATION

POLICYHOLDER:	United Business Association
POLICY NUMBER:	GAH-022 FD8-1000000
POLICY EFFECTIVE DATE:	July 4, 2013
POLICY ANNIVERSARY DATE:	July 4
STATE OF ISSUE:	Florida
CERTIFICATE NUMBER:	00000000000

(PLEASE NOTE THAT THIS SCHEDULE PAGE REPLACES ANY SCHEDULE PAGE PREVIOUSLY ISSUED TO YOU)

SCHEDULE OF BENEFITS

Covered Classes

Class 2	All active Members and enrolled Spouses and Dependent Children of the Policyholder

Time Period for Loss

Any Covered Loss must occur within:	365 days of the Covered Accident

This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in the Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Covered Person's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Member Principal Sum:	$5,000
Spouse Principal Sum:	$5,000
Dependent Child(ren) Principal Sum:	$5,000

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss 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	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	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 the Toes of the Same Foot	20% of the Principal Sum

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the S*chedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*.

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

ACCIDENT MEDICAL BENEFIT	
Deductible	$100
Accident Medical Expense Limit	$10,000

EMERGENCY TREATMENT BENEFIT	
Benefit Amount	$1,000 per visit
Maximum Number of Visits	5 per year

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GENERAL DEFINITIONS

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

Active Service

An Member will be considered in Active Service with the Policyholder on any day that is either of the following:

1. a day on which the Member meets all the conditions of membership of the Policyholder.

An eligible Dependent Child or eligible Spouse of the Member is considered in Active Service if he is none of the following:

1. an Inpatient in a Hospital; or receiving Outpatient care for chemotherapy or radiation therapy;
2. Confined at home under the care of Physician for Sickness or Injury;
3. Totally Disabled.

Aircraft

A vehicle which:

1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Certificate

The Certificate is not the Policy and is evidence of the Employee/Member's coverage under the Policy. Coverage is subject to the Policy provisions.

Complications of Pregnancy

Conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; but does not include: false labor; pre-term or premature labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning Sickness; hyperemesis gravidarum; pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Also included is: a non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Core Plan

The noncontributory plan of benefits provided under the Policy.

Covered Accident

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under the Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. is not otherwise excluded under the terms of the Policy.

Covered Injury

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

Covered Loss

A loss that is all of the following:

1. the result, directly and independently of all other causes, of a Covered Accident;
2. one of the Covered Losses specified in the Schedule of Covered Losses;
3. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits*.

Covered Person

An eligible person in a covered class, as shown in the Schedule of

Benefits: for whom an enrollment form has been accepted by Us; and required premium has been paid when due; and for whom coverage under the Policy remains in force. The term Covered Person shall include, where the Policy provides coverage, an eligible Spouse and eligible Dependent Children.

Dependent Child(ren)

A Member's child from the moment of birth to age 26 who is: (1) dependent upon the Insured for support and (2) living in the household of the Insured or is a full-time or part-time student. A child, for eligibility purposes, includes an Insured's natural child; adopted child, beginning with the time of placement in the Insured's residence; foster child; child in court-ordered temporary or other custody of the Insured; or a stepchild who resides with the Insured or depends chiefly on the Insured for financial support.

Insurance will continue for any Dependent child who reaches the age limit and continues to meet the following conditions: 1) the child is handicapped; 2) is not capable of self-support; and 3) depends chiefly on the Insured for support and maintenance. The Insured must send Us satisfactory proof that the child meets these conditions, when requested. We will not ask for proof more than once a year.

The Insured has the option of insuring his or her child at least until at leas the end of the calendar year in which the child reaches age 30 if the child is: (1) unmarried and does not have a dependent of his or her own; (2) a resident of this State or a full-time or part-time student; and (3) not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

Domestic Partner

A person of the same or opposite sex of the Insured who:

1. shares the Insured's primary residence;
2. is financially interdependent with the Insured
3. has signed a Domestic Partner declaration with the Insured, if recognized by the laws of the state in which he or she resides with the Insured;
4. does not have current Domestic Partner declaration with any other person;
5. is older than 18 years of age;
6. is not currently married to another person; and
7. is not in a position as a blood relative that would prohibit marriage.

Effective Date

The date on which insurance under the Policy begins as shown in the Schedule of Benefits.

He, His, Him

Refers to any individual, male or female.

Hospital

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;
6. it charges for its services.

Hospital shall include a Veteran's Administration Hospital or Federal

	Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived. 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; 3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.
Insured	A person: (1) who is a member of an eligible class of person as described in the Schedule of Benefits; (2) for whom premium has been paid; and (3) while covered under this Policy.
Member	For eligibility purposes, a Member is any one of the following: 1. a person who meets all of the conditions of membership of a Policyholder; and who is a United States citizen or has a permanent alien registration card and who is in one of the Covered Classes.
Physician	A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not: 1. employed or retained by the Policyholder; 2. living in the Covered Person's household; 3. a parent, sibling, spouse or child of the Covered Person.
Policy	A legal contract between the Policyholder and the Company which describes the terms and conditions of insurance subject to its provisions, limitations and exclusions.
Policyholder	The entity to which the Policy is issued and will include any affiliate or subsidiaries or divisions shown in the "Eligibility for Insurance" section.
Schedule of Benefits	A brief outline of the coverage and benefits provided by this Policy.
Sickness	A physical or mental illness including pregnancy. Complications of pregnancy are considered a Sickness.
Spouse*	The Member's lawful spouse.
***The term Spouse includes a Domestic Partner as defined.**	
Termination Date	The date on which insurance ends as defined later in this Policy.
Totally Disabled or Total Disability	Totally Disabled or Total Disability means either: 1. inability of the Covered Person to perform for the first 12 months of disability the material and substantial duties of his or her occupation; and 2. after the first 12 months of disability We may predicate the continuance of benefits on the person's ability to perform any work or occupation for which he or she is reasonably qualified or trained.
We, Us, Our	Catlin Insurance Company, Inc.
You, Your	The Member to whom the certificate is issued.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Policy Effective Date
The Insurance Company agrees to provide Accident Insurance Benefits described in the Policy in consideration of: the Policyholder's application; and payment of the initial premium when due. Insurance coverage for the Policyholder begins on the Policy Effective Date shown on the Policy's first page.

Eligibility
A Member becomes eligible for insurance under the Policy on the date: he meets all of the requirements of one of the covered classes; and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits* and is insured under the Core Plan. A Spouse and Dependent Children of an eligible Member become eligible for any dependent insurance provided by the Policy on the later of: the date the Member becomes eligible; and the date the Spouse or Dependent Child meets the applicable definition shown in the *Definitions* section of the Policy. No person may be eligible for insurance under the Policy as both a Member and a Spouse or Dependent Child at the same time.

An Member whose eligible class is changed after the Effective Date of his coverage shall become eligible under the new eligible class on the first day of the month coinciding with or next following the date of the change.

Effective Date for Individuals
Insurance becomes effective for an eligible Member on the latest of the following dates:
1. the effective date of the Policyholder under the Policy;
2. the date the Member becomes eligible;
3. the date We receive and accept the Member's completed enrollment form during his lifetime.

We may, from time to time, require the Member to re-enroll using forms supplied by Us to keep his insurance in force.

Insurance becomes effective for a Member's eligible Dependent Children on the latest of the following dates:
1. the effective date of the Policyholder under the Policy;
2. the date the Member's insurance becomes effective;
3. the date the Dependent Child meets the definition of Spouse or Dependent Child, as applicable;
4. the date We receive the Member's completed enrollment form for Spouse and Dependent Child coverage, during each Dependent Child's lifetime.

Newborn Children: A Member's newborn child is automatically covered from the moment of birth until such child is 31 days old if all other eligible children are covered under the certificate prior to the birth of the newborn child. Coverage for newborns shall be the same as for all other covered Dependent Children. The Member must notify the Company in writing within 31 days of such birth. If timely notice is given, an additional premium will not be charged for coverage of the child for the duration of the notice period. If timely notice is not given, the Member may be charged an additional premium from the date of birth. If the Member does not notify the Company within 60 days of the birth of the child,, coverage for the newborn child will not continue beyond such 60 day period.

Adopted Children: An adopted child is automatically covered for the first 31 days from: the date of placement for the purpose of adoption; or the date of the entry of an order granting the adoptive parent custody of the child if all other eligible children are covered under the certificate prior to: the date of placement; or date of the entry. Coverage for such child will be the same as for all other covered Dependent Children. The Member must: notify the Company in writing within 31 days of: the date of placement; or the date of the entry. . If timely notice is given, an additional premium will not be charged for coverage of the child for the duration of the notice period. If timely notice is not given, the Member may be charged an additional premium from the date of placement. If the Member does not notify the Company within 60 days of the placement of the child coverage for the adopted child will not continue beyond such 60 day period.

Effective Date of Changes
Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by the Policy; or
2. a change in the Member's Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

TERMINATION OF INSURANCE
The insurance on a Covered Person will end on the earliest date below:
1. the date the Policy or insurance for a covered class is terminated;
2. the date the Policyholder's coverage under the Policy ends;
3. the next premium due date after the date the Covered Person is no longer in a covered class or satisfies eligibility requirements under the Policy;
4. the last day of the last period for which premium is paid;
5. with respect to a Spouse or Dependent Child, the date of the death of the covered Member. See *Continuation of Insurance* section;
6. the date that the plan of benefits under which the Covered Person is covered is terminated.

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

EXTENSION OF BENEFITS
We will extend benefits under the Policy for 3 months after a Covered Person's coverage would otherwise end if on that date he or she is:

1. Hospital Confined for an Injury covered by the Policy; and
2. under a Doctor's care.

Any benefits payable under this provision will not exceed the benefit maximums shown in the Schedule of Benefits.

CONTINUATION OF INSURANCE
Insurance for the covered Spouse and Dependent Children may be continued if a covered Spouse's and Dependent Children's insurance would otherwise end because of death of or divorce from the covered Member. The Covered Spouse must:
1. submit a written request for continued insurance to Us within 31 days of the event; and
2. pay the required premium to the Policyholder, directly to Us.

Insurance continued under this provision may not exceed the amount of insurance in force on the day before insurance as a covered Spouse ended, nor may a Spouse add any Dependent Children for insurance.

Premiums for insurance continued under this provision will start with: the Premium Due Date on; or next following the date of the event. If a Spouse does not: elect to continue insurance under this provision; or does not provide notification within the required time period; insurance will not be continued and any premium paid from the date of the event will be refunded. However, if notification is not given to Us within the time period required in (1.) above, any return of premium will be limited to any excess paid in the last 6 months

Any Continuation of Insurance is subject to Our continuing to offer insurance under the Policy to new applicants.

COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered 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:

1. intentionally self-inflicted Injury, suicide or any attempt thereat 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. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;

5. declared or undeclared war or act of war;
6. 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;
7. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
8. participation in any motorized race or contest of speed;
9. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
10. Sickness; disease; bodily or mental infirmity; bacterial or viral infection or medical or surgical treatment thereof; except for any bacterial infection resulting from: an accidental external cut or wound; or accidental ingestion of contaminated food;
11. medical or surgical treatment; diagnostic procedure; administration of anesthesia; or medical mishap or negligence, including malpractice;
12. travel in any Aircraft owned; leased; 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;
13. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
14. 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;
15. injuries compensable under: Workers' Compensation law; or any similar law;
16. a Covered Accident that occurs while on active duty service in: the military; naval; or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY

A. This Coordination of Benefits ("COB") provision applies to This Plan when an Insured or covered Dependent has health care coverage under more than one Plan.

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

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

II. DEFINITIONS

A. **Plan** means any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs of the United States Social Security Act (42 U.S.C.A. 301 et seq.), as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

B. **This Plan** means a part of the group contract that provides benefits for health care expenses.

C. **Primary Plan/Secondary Plan** means the order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the Insured, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

D. **Allowable Expense** means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

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

E. **Claim Determination Period** means a calendar year. However, it does not include any part of a year during which an Insured has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

A. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless;

(1) The other Plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in subsection (B) below, require that This Plan's benefits be determined before those of the other Plan.

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

(1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an Insured (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, Medicare is

(a) Secondary to the Plan covering the person as a Dependent; and

(b) Primary to the Plan covering the person as other than a Dependent, for example a retired

employee.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in Subsection (B)(3) below, when This Plan and another Plan cover the same child as a Dependent of different person, called “parents:”

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the Plan which covered the parents longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in Subsection (2)(a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the Plan of the parent with custody of the child;

(b) Then, the Plan of the spouse of the parent with the custody of the child; and

(c) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Dependent Child/Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III subsection B(2) above.

(5) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (4 5) is ignored.

(6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

(a) First, the benefits of a Plan covering the person as an employee, member or subscriber (or as that person's Dependent);

(b) Second, the benefits under the continuation coverage.

If the other Plan does not contain the order of benefits determination described within this subsection, and if, as a result, the plans do not agree on the order of benefits, this requirement shall be ignored.

(7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of

benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other plans" in (B) immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. FACILITY OF PAYMENT

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

VI. RIGHT OF RECOVERY

If the amount of the payments made by Us are more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice of claim must be given to Us: within 31 days after a Covered Loss occurs or begins; or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to Us: at Our Home Office in Houston, Texas; or such other place as We may designate for the purpose; or to Our authorized agent. Notice should include: the Policyholder's name and policy number; and the Covered Person's name; address; policy; and certificate number.

Claim Forms

We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in the Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination 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.

Proof of Loss
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss; then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

The Plan Administrator of the Policyholder's employee welfare benefit plan (the Plan) has selected the Insurance Company as the Plan fiduciary under federal law for the review of claims for benefits provided by the Policy and for deciding appeals of denied claims. In this role the Insurance Company shall have the authority, in its discretion: to interpret the terms of the Plan documents; to decide questions of eligibility for coverage or benefits under the Plan; and to make any related findings of fact. All decisions made by the Insurance Company in this capacity shall be final and binding on Participants and Beneficiaries of The Plan to the full extent permitted by law.

The Insurance Company has no fiduciary responsibility with respect to the administration of The Plan except as described above. It is understood that the Insurance Company's sole liability to the Plan and to Participants and Beneficiaries under The Plan shall be for the payment of benefits provided under the Policy.

Time of Payment of Claims
We will pay benefits due under the Policy for any loss other than a loss for which the Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under the Policy, unless otherwise stated, will be payable to the covered Member or to his estate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability.

Physical Examination and Autopsy
We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No action at law or in equity may be brought to recover under the Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by the Policy. No such action will be brought more than five years after the time such written proof of loss must be furnished.

Beneficiary
The beneficiary is the person or persons the Member names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by the Policy. A separate beneficiary may be designated to receive any Accidental Death Benefit payable at the death of the Member's Spouse or Dependent Child.

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

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

If there is no named beneficiary or surviving beneficiary, or if the Member dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:
1. Spouse;
2. Child or Children;
3. mother or father;
4. sisters or brothers;
5. estate of the Member.

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods:
1. A request for lump sum payment of the overpaid amount;
2. A reduction of any amounts payable under the Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

ADMINISTRATIVE PROVISIONS

Premiums
All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for the Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect.

Changes in Premium Rates
We may change the premium rates from time to time with at least 60 days advance written notice to the Policyholder. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 6 month period. Furthermore, We reserve the right to change rates if any of the following events take place:
1. the terms of this Policy change;
2. the terms of the Policyholder's participation change;
3. a division, subsidiary, affiliated company or eligible class is added or deleted from this Policy;
4. there is a change in the factors bearing on the risk assumed;
5. any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

Payment of Premium
The first premium is due on the Policy Effective Date. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder.

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

Grace Period

1. Policy

A Policy Grace Period of 31 days will be granted for payment of required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time this Policy was in force.

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including: the endorsements; amendments; and any attached papers; constitutes the entire contract of insurance. Valid changes to this Policy may be made at any time upon 45 days written notice to the Policyholder by an endorsement or amendment signed by Us, provided that any such amendment which reduces or eliminates coverage was either requested in writing by the Policyholder or signed by the Policyholder. We may also, upon 45 days written notice to the Policyholder, change or modify the provisions of this Policy to comply with any applicable requirements of the Internal Revenue Service and any state or other federal law or regulation. No change in this Policy will be valid until: approved by one of Our executive officers; and endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

Misstatement of Fact

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

Certificates

Where required by law, We will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list: the benefits; conditions; and limits of the Policy. It will state to whom benefits will be paid.

Multiple Certificates

The Covered Person may have in force only one certificate at a time under the Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.

Assignment

The rights and benefits provided by the 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 We receive 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.

Incontestability

1. Of The Policy or Participation Under The Policy

   All statements made by the Policyholder to obtain the Policy are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; or to deny the validity of the Policy or of participation under the Policy; unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

   After two years from the Policy Effective Date, no such statement will cause the Policy to be contested except for fraud.

2. Of A Covered Person's Insurance

   All statements made by a Covered Person are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from: the Covered Person's effective date of insurance; or from the effective date of increased benefits; no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Policy Termination
We may terminate coverage on or after the first anniversary of the policy effective date. The Policyholder may terminate coverage. Written or authorized electronic notice must be given at least 31 days prior to such premium due date. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

Reinstatement
The Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are: written application of the Policyholder satisfactory to Us; 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.

Clerical Error
A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes
Any provisions in conflict with the requirements of any state or federal law that apply to the Policy are automatically changed to satisfy the minimum requirements of such laws.

Policy Changes
We may agree with the Policyholder to modify a plan of benefits without the Covered Person's consent.

Workers' Compensation Insurance
The Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

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

Examination of Records
We will be permitted to examine all of the Policyholder's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force; or it may occur:
1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all Policy claims.

The Policyholder is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Policyholder will not be considered Our actions.

DESCRIPTION OF COVERAGES AND BENEFITS

This Description of Coverages and Benefits Section describes the Accident Coverages and Benefits provided by the Policy. Benefit amounts; benefit periods; and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits.* Certain words capitalized in the text of these descriptions have special meanings within the Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms; conditions; and limitations applicable to these coverages and benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits,* if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

Definitions

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 all vision in one eye which is 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 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 the complete and permanent separation and dismemberment of the part from the body.

Exclusions

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

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

EXPOSURE AND DISAPPEARANCE COVERAGE

Benefits for Accidental Death and Dismemberment, as shown in the *Schedule of Covered Losses,* will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within 1 year from the date of: the wrecking; sinking; or disappearance of the conveyance in which the Covered Person was riding in the course

of a trip which would otherwise be covered under the Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

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

ADDITIONAL ACCIDENT BENEFITS

Accidental Death and Dismemberment benefits are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other Accidental Death and Dismemberment benefit payable.

ACCIDENT MEDICAL BENEFIT

We will pay the Usual and Customary charges for Medically Necessary Covered Medical Services after the Deductible is satisfied incurred by the Covered Person resulting from a Covered Accident. The first treatment or service must occur within 90 days of the Covered Accident and all subsequent treatments must be incurred within 52 weeks of the Covered Accident. Benefits will be paid up to the amount stated in the Certificate Schedule.

Definitions

Covered Medical Service means any of the following services, treatments or items:

- **Hospital Room and Board** – We will pay for the daily room rate when: a Covered Person is Hospital confined; and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this Covered Medical Charges, the date of admission will be counted, but not the date of discharge.
- **In-Patient Hospital Services** – We will pay for: confinement in an intensive care unit; cardiac care unit; and any other Hospital confinement.
- **Ancillary Hospital Charges** – We will pay for services and supplies including, but not limited to: operating room; laboratory tests; anesthesia; in-hospital physiotherapy; nurse services; pre-admission tests; and medicines (excluding take home drugs when Hospital Confined).
- **Medical Emergency Care and Treatment** – We will pay within 24 hours of a Covered Accident and including: attending Physician's charges; X-rays; laboratory procedures; use of the emergency room; and supplies when followed by admission to a Hospital.
- **Outpatient Surgical Charges** – We will pay for: surgical room and supply charges for use of the surgical facility; X-Rays; laboratory procedures and tests; CT scans; CAT scans; MRIs; and any radiological procedures.
- **Physician Services** – We will pay for the following Physician Services:
    1. Surgical Charges – charges for performing surgical procedures. Two or more surgical procedures through the same incision will be considered as one procedure.
    2. Assistant Physician Charges - charges by an assistant surgeon/Physician assisting the primary Physician.
    3. Other Physician Charges – charges including, but not limited to: the 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.
    4. Physician's Surgical Facilities – charges for the use of the Physician's surgical facilities.
    5. Second Opinion or Consultation – charges for a second surgical opinion or consultation.
    6. Anesthesia Charges – charges for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
    7. In-Hospital or Office Visits – charges for non-surgical treatment/examination expenses (excluding medicines) including: the Physician's initial visit; each necessary follow-up visit; and consultation visits when referred by the attending Physician.
    8. Nursing Services – charges for the services of a registered nurse (RN).
- **Physical Medicine (Physiotherapy)** – We will pay for inpatient or outpatient physiotherapy treatment(s) to include office visits connected with such treatment when prescribed by a Physician, including: diathermy; ultrasonic; whirlpool; heat treatments; adjustments; manipulation; massage; or any form of physical therapy.
- **Ambulance Services** – We will pay for ambulance service to transport the Covered Person from the emergency site to the Hospital. We will pay for ambulance transportation from the first Hospital to another Hospital, if a Physician specifies in writing that specialized care not available

in the first Hospital to which the Covered Person was transported is necessary to treat his or her Covered Injury(ies).

- **Medical Equipment Rental** – We will pay for rental or purchase, if less of a wheelchair, hospital bed or other medical equipment that has permanent or temporary therapeutic value. Permanent or temporary therapeutic value is determined by the Company.
- **Medical Services and Supplies** – We will pay for: blood and blood transfusions; oxygen; and other gases. We will pay for the cost and administration of the services and supplies.
- **Dental Services** – We will pay for dental charges including dental x-rays for the repair or treatment of each injured tooth that is whole and sound and a natural tooth at the time of the Covered Accident. Dental charges related to the installation of: crowns; caps; bridges; and dentures; oral surgery; and endodontic as a result of a Covered Accident. Repair or replacement of caps and crowns that existed prior to the Covered Accident.
- **Prescription Drugs** – We will pay for prescription 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); unless prescribed by a Physician for therapeutic use. The 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 Covered Person's Physician specifically requests that a non-generic drug be dispensed to the Covered Person.
- **Eyeglasses, Contact Lenses and Hearing Aids** – We will pay for: eyeglasses; contact lenses; and hearing aids when they are damage in a Covered Accident that requires medical treatment.
- **Artificial Instruments** – We will pay for: initial artificial limb(s); eye(s); larynx; dental device(s); and any other orthopedic prosthetic appliance(s); including fitting. We will not pay for future repair or replacement of artificial: limb(s); eye(s); larynx; dental device(s); or any other orthopedic prosthetic appliance(s).
- **Rehabilitation Treatment** - We will pay for physical and occupational rehabilitation. Treatment must be provided in a duly licensed Rehabilitation Facility and be under the direction of a Physician.
- **Skilled Nursing Facility** – We will pay for services at a valid skilled nursing facility where such location is dedicated to the care of individuals in a residential facility, usually there on a long-term basis. These facilities specialize in the watching, but not serious enough where hospitalization is required.

Hospital Confine(d) means admission to a Hospital as a registered resident bed-patient for at least 24 consecutive hours by a Physician.

Rehabilitation Facility means a Hospital or special unit of a Hospital designated as a Rehabilitation Facility or a free standing facility which provides: physical therapy; occupational therapy; or speech therapy pursuant to the law of the jurisdiction in which treatment is received.

Extended Care Facility means an institution operating pursuant to applicable laws that is engaged in providing, for a fee, inpatient skilled nursing care and related services under the supervision of a Physician and registered. It must have facilities for 10 or more inpatients and maintain medical records of all its patients.

Home Health Care means: nursing care; treatment; and items necessary to a person's care and health provided in the Covered Person's house as part of an overall extended treatment plan. To qualify for Home Health Care:

1. The Home Health Care must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care;
2. Nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified home health care agency and nursing service; and
3. Items necessary to a person's care and health must be provided by the attending Physician or by the provider of the nursing care services.

Pre-Existing Conditions means a physical or mental condition of the Covered Person, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending immediately preceding the effective date of the Covered Person's coverage.

Medical Repatriation means transporting a Covered Person back to his or her Primary Residence or to the country where he or she was assigned. Such repatriation shall only result from the Covered Person being injured during a Covered Activity.

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

Deductible means the dollar amount of Covered Medical Charges that must be occurred as an out of pocket charge by each Covered Person on a per Covered Accident basis before Accident Medical Benefit benefits are payable under this Rider.

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

1. Group or blanket insurance, whether on an Insured or self-funded basis;
2. Hospital or medical service organizations on a group basis;
3. Health Maintenance Organization plans;
4. Group labor management plans;
5. Employee benefit organization plan;
6. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

Covered Expenses means expenses incurred by or on behalf of a Covered Person for: treatment; services; and supplies covered by this Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Covered Accident until the date: treatment; services; or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such: treatment; service; or supply; that gave rise to the expense or the charge, was rendered or obtained.

Pro Rata means the portion of the total benefits payable under this Policy, in the absence of other insurance, relative to the total benefits payable under all Health Care Plans. In no event will the total benefits payable exceed 100% of the incurred expense.

Exclusions

In addition to the General Exclusions stated in the Policy, We will not cover charges under this Rider for:

1. Pre-Existing Conditions; within the 12 months immediately following the the Covered Person's Effective Date or, in the case of late enrollees, within the 18 months immediately following the Covered Person's Effective Date;
2. Treatment by persons employed or retained by the Policyholder, or by any Immediate Family Member or member of the Covered Person's household;
3. Treatment of: sickness; disease; or infection except: pyogenic infection; or viral or bacterial infections that result from the accidental ingestion of contaminated food substance;
4. Treatment of: hernia; Osgood-Schlatter's Disease; osteochondritis; appendicitis; osteomyelitis; cardiac disease or conditions; pathological fractures; congenital weakness; detached retina unless caused by a Covered injury or mental disorder; or psychological or psychiatric care/counseling or treatment (except as provided in the Policy), whether or not caused by a Covered Accident;
5. Pregnancy; childbirth; miscarriage; abortion; or any complication of: childbirth; miscarriage; or abortion; unless due to a Covered Injury;
6. Mental and Nervous Disorder (except as provided in the Policy);
7. Damage to or loss of dentures or bridges; or damage to existing orthodontic equipment (except as specifically covered by the Policy);
8. Charges incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofacial pain (except as provided by the Policy);
9. Charges for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
10. Charges for injuries caused while: riding in or on; entering into or alighting from; or being struck by a 2 or 3-wheeled motor vehicle; or a motor vehicle not designed primarily for use on public streets or highways;

11. Participation in or practice for: interscholastic tackle football; intercollegiate sports; semi-professional sports; or professional sports (unless specifically covered under the Policy);
12. Covered Medical Charges for which the Covered Person would not be responsible for in the absence of this Policy;
13. Conditions that are not caused by a Covered Accident;
14. Any elective: treatment; surgery; health treatment; or examination; (including any: service; treatment; or supplies that: (a) are deemed by Us to be experimental; or (b) are not recognized and generally accepted medical practices in the United States;
15. Charges payable by any automobile insurance policy without regard to fault (this exclusion does not apply in any state where prohibited);
16. Orthopedic appliance used mainly to protect an Injury so that a Covered Person can take part in the Covered Activity;
17. Treatment of injuries that result over a period of time (such as: blisters; tennis elbow; etc.);
18. Treatment or services provided by a private duty nurse;
19. Replacement of artificial: limbs; eyes; larynx; dental devices; or any other prosthetic appliances;
20. Blood; blood plasma; or blood storage; except charges by a Hospital for processing or administration of blood;
21. Cosmetic; plastic; or restorative surgery; except needed as a result of the Covered Injury;
22. Any: treatment; service; or supply not specifically covered by the Policy;
23. Personal comfort or convenience items, such as but not limited to: Hospital telephone charges; television rental; or guest meals;
24. Charges incurred for: dental care; treatment; repair; or replacement of sound natural teeth;
25. Charges incurred for: eye examinations; eye glasses; contact lenses; or hearing aids or the: fitting; repair; or replacement of these items;
26. Routine physical examinations and related medical services; elective treatment or surgery; or investigative treatments of procedures;
27. A Medical Repatriation;
28. Charges for rest cures or custodial care;
29. Treatment in any: Veteran's Administration; Federal or state facility; unless there is a legal obligation to pay;
30. Services or treatment provided by an infirmary operated by the Policyholder;
31. Chiropractic treatment;
32. Treatment of an injury resulting from or contributing to by: frostbite; fainting; or seizures; or heatstroke; or heat exhaustion;
33. aggravation of an injury the Covered Person suffered before participating in the activity, unless We receive a written medical release from the Covered Person's Physician;

Scope of Coverage

Full Excess Benefits – If a Covered Person incurs Covered Medical Charges, We will pay the applicable benefit, subject to any applicable Deductible and Benefit Period shown on the Schedule of Benefits that are in excess of amounts payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

Failure by a Covered Person to follow the terms and conditions of his or her primary coverage will result in a benefit reduction of Covered Medical Charges to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after a Covered Accident. Such Covered Accident must occur outside the geographic area served by the primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

FRAUD NOTICE

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STATE SPECIFIC PROVISIONS

Arkansas	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Hawaii	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.
Maryland	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York

All commercial insurance forms, except as provided for automobile insurance:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Automobile insurance forms
Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

Fire Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.

Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
In order for us to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on your part, we must show that:

A. The misinformation is material to the content of the policy;

B. We relied upon the misinformation; and

C. The information was either:

- **1.** Material to the risk assumed by us; or
- **2.** Provided fraudulently.

For remedies other than the denial of a claim, misstatements, misrepresentations, omissions or concealments on your part must either be fraudulent or material to our interests.

With regard to fire insurance, in order to trigger the right to remedy, material misrepresentations must be willful or intentional.

Misstatements, misrepresentations, omissions or concealments on your part are not fraudulent unless they are made with the intent to knowingly defraud.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Auto: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.

Puerto Rico

Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars ($5,000), not to exceed ten thousands dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Rhode Island

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

West Virginia

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC")

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Policyholder Notice provides information concerning the possible impact on your insurance coverage provided under your policy due to directives issued by OFAC. Please read this Policyholder Notice carefully.

OFAC administers and enforces economic and trade sanctions based on US foreign policy and national security goals based on Presidential declarations of "national emergency." OFAC has identified and listed numerous:

- Foreign agents
- Front organizations
- Terrorists
- Terrorist organizations
- Narcotics traffickers

as "Specially Designated Nationals and Blocked Persons." This list can be found on the United States Treasury's web site – http://www.treas.gov/ofac.

In accordance with OFAC regulations, if it is determined that you or any other insured, or any person or entity claiming the benefits of this insurance has violated US sanctions law or is a Specially Designated National and Blocked Person, as identified by OFAC, this insurance will be considered a blocked or frozen contract and all provisions of this insurance will be immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments may also apply.

PRIVACY POLICY

Catlin insurance group [the "Companies"], believes personal information that we collect about our customers, potential customers, and proposed insureds [referred to collectively in this Privacy Policy as "customers"] must be treated with the highest degree of confidentiality. For this reason and in compliance with the Title V of the Gramm-Leach-Bliley Act ["GLBA"], we have developed a Privacy Policy that applies to all of our companies. For purposes of our Privacy Policy, the term "personal information" includes all information we obtain about a customer and maintain in a personally identifiable way. In order to assure the confidentiality of the personal information we collect and in order to comply with applicable laws, all individuals with access to personal information about our customers are required to follow this policy.

Our Privacy Promise

Your privacy and the confidentiality of your business records are important to us. Information and the analysis of information is essential to the business of insurance and critical to our ability to provide to you excellent, cost-effective service and products. We understand that gaining and keeping your trust depends upon the security and integrity of our records concerning you. Accordingly, we promise that:

1. We will follow strict standards of security and confidentiality to protect any information you share with us or information that we receive about you;
2. We will verify and exchange information regarding your credit and financial status only for the purposes of underwriting, policy administration, or risk management and only with reputable references and clearinghouse services;
3. We will not collect and use information about you and your business other than the minimum amount of information necessary to advise you about and deliver to you excellent service and products and to administer our business;
4. We will train our employees to handle information about you or your business in a secure and confidential manner and only permit employees authorized to use such information to have access to such information;
5. We will not disclose information about you or your business to any organization outside the Catlin insurance group of Companies or to third party service providers unless we disclose to you our intent to do so or we are required to do so by law;
6. We will not disclose medical information about you, your employees, or any claimants under any policy of insurance, unless you provide us with written authorization to do so, or unless the disclosure is for any specific business exception provided in the law;
7. We will attempt, with your help, to keep our records regarding you and your business complete and accurate, and will advise you how and where to access your account information [unless prohibited by law], and will advise you how to correct errors or make changes to that information; and
8. We will audit and assess our operations, personnel and third party service providers to assure that your privacy is respected.

Collection and Sources of Information

We collect from a customer or potential customer only the personal information that is necessary for [a] determining eligibility for the product or service sought by the customer, [b] administering the product or service obtained, and [c] advising the customer about our products and services. The information we collect generally comes from the following sources:

Submission – During the submission process, you provide us with information about you and your business, such as your name, address, phone number, e-mail address, and other types of personal identification information;

Quotes – We collect information to enable us to determine your eligibility for the particular insurance product and to determine the cost of such insurance to you. The information we collect will vary with the type of insurance you seek;

Transactions – We will maintain records of all transactions with us, our affiliates, and our third party service providers, including your insurance coverage selections, premiums, billing and payment information, claims history, and other information related to your account;

Claims – If you obtain insurance from us, we will maintain records related to any claims that may be made under your policies. The investigation of a claim necessarily involves collection of a broad range of information about many issues, some of which does not directly involve you. We will share with you any facts that we collect about your claim unless we are prohibited by law from doing so. The process of claim investigation, evaluation, and settlement also involves, however, the collection of advice, opinions, and comments from many people, including attorneys and experts, to aid the claim specialist in determining how best to handle your claim. In order to protect the legal and transactional confidentiality and privileges associated with such opinions, comments and advice, we will not disclose this information to you; and

Credit and Financial Reports – We may receive information about you and your business regarding your credit. We use this information to verify information you provide during the submission and quote processes and to help underwrite and provide to you the most accurate and cost-effective insurance quote we can provide.

Retention and Correction of Personal Information

We retain personal information only as long as required by our business practices and applicable law. If we become aware that an item of personal information may be materially inaccurate, we will make reasonable effort to re-verify its accuracy and correct any error as appropriate.

Storage of Personal Information

We have in place safeguards to protect data and paper files containing personal information.

Sharing/Disclosing of Personal Information

We maintain procedures to assure that we do not share personal information with an unaffiliated third party for marketing purposes unless such sharing is permitted by law. Personal information may be disclosed to an unaffiliated third party for necessary servicing of the product or service or for other normal business transactions as permitted by law.

We do not disclose personal information to an unaffiliated third party for servicing purposes or joint marketing purposes unless a contract containing a confidentiality/non-disclosure provision has been signed by us and the third party. Unless a consumer consents, we do not disclose “consumer credit report” type information obtained from an application or a credit report regarding a customer who applies for a financial product to any unaffiliated third party for the purpose of serving as a factor in establishing a consumer’s eligibility for credit, insurance or employment. “Consumer credit report type information” means such things as net worth, credit worthiness, lifestyle information [piloting, skydiving, etc.] solvency, etc. We also do not disclose to any unaffiliated third party a policy or account number for use in marketing. We may share with our affiliated companies information that relates to our experience and transactions with the customer.

Policy for Personal Information Relating to Nonpublic Personal Health Information

We do not disclose nonpublic personal health information about a customer unless an authorization is obtained from the customer whose nonpublic personal information is sought to be disclosed. However, an authorization shall not be prohibited, restricted or required for the disclosure of certain insurance functions, including, but not limited to, claims administration, claims adjustment and management, detection, investigation or reporting of actual or potential fraud, misrepresentation or criminal activity, underwriting, policy placement or issuance, loss control and/or auditing.

Access to Your Information

Our employees, employees of our affiliated companies, and third party service providers will have access to information we collect about you and your business as is necessary to effect transactions with you. We may also disclose information about you to the following categories of person or entities:

Your independent insurance agent or broker;

An independent claim adjuster or investigator, or an attorney or expert involved in the claim;

Persons or organizations that conduct scientific studies, including actuaries and accountants;

An insurance support organization;

Another insurer if to prevent fraud or to properly underwrite a risk;

A state insurance department or other governmental agency, if required by federal, state or local laws; or

Any persons entitled to receive information as ordered by a summons, court order, search warrant, or subpoena.

Violation of the Privacy Policy

Any person violating the Privacy Policy will be subject to discipline, up to and including termination.

For more information or to address questions regarding this privacy statement, please contact your broker.