TRUIST

Summary Plan Description

Truist Financial Corporation
Business Travel Accident Insurance Plan

As of January 1, 2025

INTRODUCTION

Introduction

Truist Financial Corporation maintains the Truist Financial Corporation Business Travel Accident Insurance Plan (the "Plan"). The purpose of the Plan is to provide accidental death and dismemberment benefits for eligible teammates as specified in this document.

Purpose of this Document

The Plan is an employee welfare benefit plan subject to certain requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan.

This document, together with the certificate of insurance booklet (the "Certificate of Insurance") issued by the Hartford Fire Insurance (the "Insurance Company"), is the governing Plan Document and Summary Plan Description ("SPD") for the Plan. The benefits described in this SPD are provided under a group insurance policy ("Policy") issued by the Insurance Company. The Insurance Company is designated and named the claims fiduciary for benefits provided under the Policy. The Insurance Company has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law. Benefits under the Plan are described in the Certificate of Insurance, a copy of which is attached to this document as Appendix B.[1]

We encourage plan participants to read this SPD carefully. If you have any questions regarding the information in the SPD, contact the Plan Administrator whose name and address are listed below. This document is not intended to give you any substantive rights to benefits that are not already provided by the attached Certificate of Insurance. It is your responsibility to become familiar with the SPD (that is, this document and the attached Certificate of Insurance) and to ask questions if you do not understand how the requirements impact you.

[1] If the terms of this SPD conflict with the terms of the certificate of insurance, then the terms of the certificate of insurance will control, unless superseded by applicable law.

REQUESTS FOR PLAN DOCUMENTS

Requests for plan documents must be in writing and sent to the Plan Administrator at:

Chairman, Employee Benefits Committee
Truist Financial Corporation
214 N Tryon Street, 45th Floor
Charlotte NC 28202

Failure to send a written request to the address above will not constitute a request for plan documents.

FACTS ABOUT THE PLAN

1. **Plan Name**
   Truist Financial Corporation Business Travel Accident Plan

2. **Plan Number**
   506

3. **Employer/Plan Sponsor (Policyholder)**
   TRUIST FINANCIAL CORP.
   214 N Tryon Street, Floor 45
   Charlotte NC 28202

4. **Employer Identification Number**
   56-0939887

5. **Type of Plan**
   Welfare Benefit Plan providing Business Travel Accident Insurance.

6. **Plan Administrator**
   Employee Benefits Plan Committee
   TRUIST FINANCIAL CORP.
   214 N Tryon Street, Floor 45
   Charlotte NC 28202

7. **Agent for Service of Legal Process**
   For the Plan:
   TRUIST FINANCIAL CORP.
   214 N Tryon Street, Floor 45
   Charlotte NC 28202

   For the Policy:
   Hartford Fire Insurance
   One Hartford Plaza Hartford,
   Connecticut 06155

   In addition to the above, Service of Legal Process may be made on the Plan Administrator.

8. **Sources of Contributions**.
   The Employer pays the entire premium for the benefit.

9. **Type of Administration**
   The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

10. **Plan Year**
    The Plan and its records are kept on a Policy Year basis (which is the calendar year).

11. Labor Organizations

None

12. Names and Addresses of Trustees

None

13. Plan Amendment Procedure

The Plan Sponsor reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice. The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Eligibility and Participation Requirements

For information regarding whether you are eligible to participate in the Plan and /or when coverage begins and ends, please read the eligibility information contained in the attached Certificate of Insurance.

Summary of Plan Benefits

A summary of the benefits provided under the Plan is set forth in the attached Certificate of Insurance.

How the Plan Is Administered

Plan Operations

Because benefits are provided through an insurance contract, the Plan is administered by both the Plan Sponsor and the Insurance Company.

Plan Administration

The Plan Sponsor has named the Employee Benefits Plan Committee ("Committee") as the Plan Administrator of the Plan. The Committee shall be the Plan Administrator, and the Chairman of the Committee shall be the agent for service of legal process on the plan.

As the Plan Administrator, the Committee is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs and, as required, filing an annual report about the Plan with the government).

The Committee shall consist of a Chairman, designated in the Committee's charter and not less than three (3) individuals appointed by the Chairman. The Chairman may appoint a secretary who will not be a Committee member. Any member of the Committee may resign, and his successor, if any, shall be appointed by the Chairman.

The Committee has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Power and Authority of Insurance Company

The Plan is fully insured. Benefits are provided under a group insurance contract entered into between the Plan Sponsor and the Insurance Company. Claims for benefits are sent to the Insurance Company. The Insurance Company, not the Plan Sponsor, is responsible for determining and paying claims.

The Insurance Company is the named fiduciary for administering claims and is responsible for:

- Determining eligibility for a benefit and the amount of any benefits payable under the Plan; and
- Providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan.

The Insurance Company also has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

ALLOCATION OF RESPONSIBILITIES AMONG NAMED FIDUCIARIES

Duties of Named Fiduciaries

The named fiduciaries with respect to the plan and the fiduciary duties and other responsibilities allocated to each, which shall be carried out in accordance with the other applicable terms and provisions of the plan, shall be as follows:

1) Plan Administrator

    a) To interpret the provisions of the Plan and determine the rights of participants under the Plan, except to the extent such powers are delegated to another named fiduciary or other person or persons as provided in this SPD;[2]
    b) To administer the Plan in accordance with its terms, except to the extent such powers are delegated to another named fiduciary or other person or persons as provided in this SPD;
    c) To file such reports as may be required with the United States Department of Labor, the Internal Revenue Service and any other government agency to which reports may be required to be submitted from time to time;
    d) To comply with requirements of the law for disclosure of plan provisions and other information relating to the plan to participants and other interested parties; and
    e) To administer the claims procedure to the extent allocated to it in this SPD.

2) Claims Fiduciary.

    a) To adjudicate claims for benefits under the Plan;
    b) To administer the claims procedures to the extent allocated to it in this SPD.

3) Compensation and Human Capital Committee.

    a) The Compensation and Human Capital Committee of the Board will be responsible for approving the Charter of the Employee Benefits Plan Committee; and

[2] When the Committee makes such interpretations and determinations, it does so with full discretionary authority and the interpretations and determinations made by the Committee will (i) apply uniformly to all persons similarly situated, and (ii) be binding and conclusive upon all interested persons. Such interpretations and determinations will only be set aside if a court of competent jurisdiction finds that the Committee acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

b) The Compensation and Human Capital Committee of the Board may delegate its responsibilities to the appropriate officers of the Company.

Co-fiduciary Liability

Except as otherwise provided in ERISA, a named fiduciary shall not be responsible or liable for any act or omission of another named fiduciary with respect to fiduciary responsibilities allocated to such other named fiduciaries. A named fiduciary of the plan shall be responsible and liable only for its own acts or omissions with respect to fiduciary duties specifically allocated to it and designated as its responsibility.

CLAIMS PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Plan. The Insurance Company has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan, to the extent permitted by applicable state law. The interpretations and determinations by the Insurance Company will apply uniformly to all persons similarly situated and will be binding and conclusive upon all interested persons. Such interpretations and determinations will only be set aside if a court of competent jurisdiction finds that the Insurance Company acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

Benefit Claim

The Insurance Company is responsible for evaluating all benefit claims under the Plan. The Insurance Company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the attached Certificate of Insurance issued by the Insurance Company for information about how to file a claim and for details regarding the Insurance Company's claims procedures.

Appealing Denied Claim

If your claim is denied (that is, not paid in part or in full), you will be notified and you may appeal to the Insurance Company for a review of the denied claim. The Insurance Company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the attached Certificate of Insurance issued by the Insurance Company for information about how to file a claim and for details regarding the Insurance Company's claims procedures.

Important Appeal Deadlines

If you do not appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a condition for bringing suit in court). See the attached Certificate of Insurance for information about how to appeal a denied claim, and for details regarding the Insurance Company's appeals procedures.

Exhaustion of Administrative Remedies; Limitations of Actions

Claimants shall not be entitled to challenge the Committee's determinations in judicial or administrative proceedings without first complying with the administrative claims procedures set forth in this SPD, as appropriate. All such claims must be brought within the timeframes set forth above for the Claimant's type of claim. The decisions made pursuant to applicable administrative claims procedures are final and binding on the Claimant and any other party.

If the Claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his right to bring civil action under ERISA Section 502(a), the Claimant must bring such action within 12 months following the date on which he submitted the last required appeal (or voluntary appeal, if offered and the Claimant files a voluntary appeal) under such procedures unless the claim is a claim for benefits, which is determined by the Insurance Company—and not a claim related to eligibility to participate, which is determined by the Committee—and a different period is provided in the Certificate of Insurance. If the Claimant does not bring such action within such 12-month period, the Claimant shall be barred from bringing an action under ERISA related to his claim.

Incompetency

If any person entitled to payments under the Plan is a minor or under other legal disability or otherwise incapacitated so as to be unable to manage his financial affairs or is otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. If the payment is to be made by an Insurance Company, such payment shall be made in accordance with the terms of the contract under which such benefit is payable. If the payment is to be otherwise made, the Committee, in its discretion, may direct that all or any portion of such payment be made:

(i) to such person;
(ii) to such person's legal guardian or conservator; or
(iii) to such person's Spouse or to any other person,

in any manner the Committee considers advisable, to be expended for his benefit. The decision of the Committee (or, where applicable, that of the Insurance Company) shall, in each case, be final and binding upon all persons.

ANTI-ASSIGNMENT

Benefits available under this Plan are not assignable by any Participant or Beneficiary. No individual may at any time assign his or her right under the Plan or any of the benefits available under the Plan to any party, his / her right to benefits under this Plan, nor may he/she assign any administrative, statutory, or legal rights or causes of action he / she may have under ERISA or other federal / state law, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances. Under no circumstances shall any payments or communications made to any party be interpreted or considered as a waiver of this anti-assignment provision.

Amendment and Termination

Truist has reserved the right, by written action of its Board of Directors or its authorized officer, to modify, amend or terminate the Plan at anytime. Except as otherwise provided in the Plan, the right to modify, amend or terminate the Plan will not in any way affect your right to claim benefits, or diminish or eliminate any claims for benefits under the Plan to which you may have become entitled to claim prior to such termination or amendment. The Plan is not a contract, and Truist does not guarantee and makes no promise to offer a specific level of benefits in the future. The right to future benefits under the Plan will never vest.

Neither the Plan nor the benefits provided under the Plan can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, the Insurance Company, by any delegate of the Plan Administrator or Insurance Company, or by other party. Only written statements that are consistent with the terms of the Plan and made by the Plan Administrator and /or Insurance Company can bind the Plan.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Plan Sponsor to the effect that you will be employed for any specific period of time.

Governing Law and Venue

This Plan is governed by and will be construed in accordance with ERISA, and to the extent not preempted by ERISA, by the laws of the state of North Carolina, without regard for any choice of law principles thereof. Unless otherwise provided in this SPD, any legal action related to this Plan shall be brought only in the United States District Court for the Western District of North Carolina and of any court situated in Charlotte, North Carolina.

Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan), please contact the Committee.

If you have questions regarding eligibility for a benefit and/or the amount of any benefits payable under the Plan, please contact the Insurance Company.

* * * * *

APPENDIX A
PARTICIPATING EMPLOYERS

As of January 1, 2025, the list of participating employers is provided below. This list may be updated by separate agreement between such employer and a Senior Executive Vice President of the Company and without formal amendment to this SPD.

AFCO Acceptance Corporation
AFCO Credit Corporation
BB&T Collateral Service Corporation
BB&T Real Estate Funding, LLC
CB Finance, Inc.
GFO Advisory Services, LLC
Grandbridge Real Estate Capital, LLC
Prime Rate Premium Finance Corporation, Inc.
Regional Acceptance Corporation
Service Finance Holdings, LLC
SunTrust Equity Funding, LLC
Truist Commercial Equity
Truist Advisory Services, Inc.
Truist Bank
Truist CIG, LLC
Truist Community Capital, LLC
Truist Delaware Trust Company
Truist Equipment Finance Corp
Truist Investment Services, Inc.
Truist Leasing Corp
Truist Merchant Services LLC
Truist Securities, Inc.

APPENDIX B
CERTIFICATE OF INSURANCE BOOKLET
ISSUED BY
THE HARTFORD FIRE INSURANCE COMPANY

CERTIFICATE OF INSURANCE

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

Policyholder: Truist Financial Corp.
Policy Number: 22-GTA-101220
Policy Effective Date: January 1, 2020

We have issued a Policy to the Policyholder. The Policy is delivered in and governed by the state of North Carolina, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (as amended). The provisions of the Policy which are important to the Insured Person are summarized in this Certificate. This Certificate replaces all Certificates which We may have been given to the Insured Person earlier for the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy. The Policy may be inspected at the office of the Policyholder.

Important Cancellation Information – Please Read the provision entitled, POLICY EFFECTIVE AND TERMINATION DATES Found On Page 12.

This Certificate is renewable at the option of the Policyholder

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, you should review the Guide to Health Insurance for People with Medicare available from Us.

Signed for Hartford Fire Insurance Company at Hartford, Connecticut.

Kevin Barnett, *Secretary*

Douglas Elliot, *President*

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

Policyholder: Truist Financial Corp.
Policy Number: 22-GTA-101220

POLICY AMENDATORY RIDER

This Rider is attached to and made part of the Policy as of 1/1/2023. It applies only with respect to Covered Accidents 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.

Rider # **1**:

In consideration of the Policy Premium, the Policy Period shall be renewed effective 1/1/2023 to 1/1/2026.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Kevin Barnett, *Secretary*

Douglas Elliot, *President*

Form BTA-1200

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SCHEDULE

DESCRIPTION OF ELIGIBLE CLASS(ES):

Class	Description of Class(es)
1	**All Chairman, Chief Executive Officer, Chief Adminstrative Officer, Presidents, Senior Executive Vice Presidents, Executive Vice Presidents, Regional Presidents, Senior Vice Presidents of the Policyholder.**
2	**All Corporate Board Members of the Policyholder.**
3	**All other regular, active employees who are scheduled to work at least 20 hours per work week of the Policyholder.**
4	**All Advisory Board Members of the Policyholder.**
5	**The Spouse of a Primary Insured Person.**
6	**The Dependent Children of a Primary Insured Person.**

PRINCIPAL SUM

Class 1 **Accidental Death & Dismemberment**	$500,000
Class 2 **Accidental Death & Dismemberment**	$500,000
Class 3 **Accidental Death & Dismemberment**	$250,000
Class 4 **Accidental Death & Dismemberment**	$250,000
Class 5 **Accidental Death & Dismemberment**	$50,000
Class 6 **Accidental Death & Dismemberment**	$25,000

AGGREGATE LIMIT $10,000,000 Per Covered Accident
$3,500,000 Per Policyholder Aircraft Accident

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	Accidental Death and Dismemberment (AD&D)	See Benefit(s) page
2	H-1, H-4, H-32	Accidental Death and Dismemberment (AD&D)	See Benefit(s) page
3	H-3, H-4, H-8, H-15, H-32	Accidental Death and Dismemberment (AD&D)	See Benefit(s) page
4	H-4, H-8, H-15, H-26, H-32	Accidental Death and Dismemberment (AD&D)	See Benefit(s) page
5	H-7, H-21	Accidental Death and Dismemberment (AD&D)	See Benefit(s) page
6	H-7, H-21	Accidental Death and Dismemberment (AD&D)	See Benefit(s) page

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
2	H-1, H-4, H-32	B-2 Accident Medical Expense	See Benefit(s) page

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-4 Adaptive Home & Vehicle	Benefit Amount of $50,000
2	H-1, H-4, H-32	B-4 Adaptive Home & Vehicle	Benefit Amount of $50,000
3	H-3, H-4, H-8, H-15, H-32	B-4 Adaptive Home & Vehicle	Benefit Amount of $50,000
4	H-4, H-8, H-15, H-26, H-32	B-4 Adaptive Home & Vehicle	Benefit Amount of $50,000
5	H-7, H-21	B-4 Adaptive Home & Vehicle	Benefit Amount of $50,000
6	H-7, H-21	B-4 Adaptive Home & Vehicle	Benefit Amount of $50,000

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-7 Bereavement Counseling	$150 per session 10 Maximum Number of Sessions
2	H-1, H-4, H-32	B-7 Bereavement Counseling	$150 per session 10 Maximum Number of Sessions
3	H-3, H-4, H-8, H-15, H-32	B-7 Bereavement Counseling	$150 per session 10 Maximum Number of Sessions
4	H-3, H-4, H-8, H-15, H-32	B-7 Bereavement Counseling	$150 per session 10 Maximum Number of Sessions
5	H-7, H-21	B-7 Bereavement Counseling	$150 per session 10 Maximum Number of Sessions
6	H-7, H-21	B-7 Bereavement Counseling	$150 per session 10 Maximum Number of Sessions

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-13 Coma	Maximum Benefit Amount of $500,000 1% of the Maximum Benefit Amount per month for the Monthly
2	H-1, H-4, H-32	B-13 Coma	Maximum Benefit Amount of $500,000 1% of the Maximum Benefit Amount per month for the Monthly
3	H-3, H-4, H-8, H-15, H-32	B-13 Coma	Maximum Benefit Amount of $500,000 1% of the Maximum Benefit Amount per month for the Monthly
4	H-3, H-4, H-8, H-15, H-32	B-13 Coma	Maximum Benefit Amount of $500,000 1% of the Maximum Benefit Amount per month for the Monthly
5	H-7, H-21	B-13 Coma	Maximum Benefit Amount of $500,000 1% of the Maximum Benefit Amount per month for the Monthly
6	H-7, H-21	B-13 Coma	Maximum Benefit Amount of $500,000 1% of the Maximum Benefit Amount per month for the Monthly

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-21 Education Expense	5% of $25,000
2	H-1, H-4, H-32	B-21 Education Expense	5% of $25,000
3	H-3, H-4, H-8, H-15, H-32	B-21 Education Expense	5% of $25,000
4	H-4, H-8, H-15, H-26, H-32	B-21 Education Expense	5% of $25,000
5	H-7, H-21	B-21 Education Expense	5% of $25,000

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-32 Medical Emergency Evacuation	actual cost of the Medical Emergency Evacuation
2	H-1, H-4, H-32	B-32 Medical Emergency Evacuation	actual cost of the Medical Emergency Evacuation
3	H-3, H-4, H-8, H-15, H-32	B-32 Medical Emergency Evacuation	actual cost of the Medical Emergency Evacuation
4	H-4, H-8, H-15, H-26, H-32	B-32 Medical Emergency Evacuation	actual cost of the Medical Emergency Evacuation
5	H-7, H-21	B-32 Medical Emergency Evacuation	actual cost of the Medical Emergency Evacuation
6	H-7, H-21	B-32 Medical Emergency Evacuation	actual cost of the Medical Emergency Evacuation

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-39 Paralysis	See Benefit(s) page.
2	H-1, H-4, H-32	B-39 Paralysis	See Benefit(s) page.
3	H-3, H-4, H-8, H-15, H-32	B-39 Paralysis	See Benefit(s) page.
4	H-3, H-4, H-8, H-15, H-32	B-39 Paralysis	See Benefit(s) page.
5	H-7, H-21	B-39 Paralysis	See Benefit(s) page.
6	H-7, H-21	B-39 Paralysis	See Benefit(s) page.

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-40 Permanent Total Disability (Lump Sum)	$500,000
2	H-1, H-4, H-32	B-40 Permanent Total Disability (Lump Sum)	$500,000
3	H-3, H-4, H-8, H-15, H-32	B-40 Permanent Total Disability (Lump Sum)	$250,000
4	H-4, H-8,H-15, H-26, H-32	B-40 Permanent Total Disability (Lump Sum)	$250,000
5	H-7, H-21	B-40 Permanent Total Disability (Lump Sum)	$50,000
6	H-7, H-21	B-40 Permanent Total Disability (Lump Sum)	$25,000

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-49 Rehabilitation Expense	$50,000
2	H-1, H-4, H-32	B-49 Rehabilitation Expense	$50,000
3	H-3, H-4, H-8, H-32	B-49 Rehabilitation Expense	$50,000
4	H-3, H-4, H-8, H-32	B-49 Rehabilitation Expense	$50,000
5	H-7, H-21	B-49 Rehabilitation Expense	$50,000
6	H-7, H-21	B-49 Rehabilitation Expense	$50,000

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-50 Repatriation of Remains	actual cost of the Repatriation Remains
2	H-1, H-4, H-32	B-50 Repatriation of Remains	actual cost of the Repatriation Remains
3	H-3, H-4, H-8, H-32	B-50 Repatriation of Remains	actual cost of the Repatriation Remains
4	H-3, H-4, H-8, H-32	B-50 Repatriation of Remains	actual cost of the Repatriation Remains
5	H-7, H-21	B-50 Repatriation of Remains	actual cost of the Repatriation Remains
6	H-7, H-21	B-50 Repatriation of Remains	actual cost of the Repatriation Remains

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-51 Seat Belt and Airbag	10% of $50,000
2	H-1, H-4, H-32	B-51 Seat Belt and Airbag	10% of $50,000
3	H-3, H-4, H-8, H-32	B-51 Seat Belt and Airbag	10% of $50,000
4	H-3, H-4, H-8, H-32	B-51 Seat Belt and Airbag	10% of $50,000
5	H-7, H-21	B-51 Seat Belt and Airbag	10% of $50,000
6	H-7, H-21	B-51 Seat Belt and Airbag	10% of $50,000

CLASS(ES)	HAZARD(S)	BENEFIT	AMOUNT
1	H-3, H-4, H-8, H-15, H-32	B-55 Therapeutic Counseling	Benefit Amount of $150 per maximum number of 10 sessions
2	H-1, H-4, H-32	B-55 Therapeutic Counseling	Benefit Amount of $150 per maximum number of 10 sessions
3	H-3, H-4, H-8, H-32	B-55 Therapeutic Counseling	Benefit Amount of $150 per maximum number of 10 sessions
4	H-3, H-4, H-8, H-32	B-55 Therapeutic Counseling	Benefit Amount of $150 per maximum number of 10 sessions
5	H-7, H-21	B-55 Therapeutic Counseling	Benefit Amount of $150 per maximum number of 10 sessions
6	H-7, H-21	B-55 Therapeutic Counseling	Benefit Amount of $150 per maximum number of 10 sessions

DEFINITIONS

Accident, Accidental means a sudden, abrupt, and unexpected event.

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

Airworthiness Certificate means a valid and current "Standard Airworthiness Certificate" issued by the FAA.

Alcohol and Substance Abuse means the overindulgence in or dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's physical or mental health or the welfare of others.

Ambulatory Surgical Center (ASC) or **Ambulatory Medical Center** means a licensed healthcare facility where surgical procedures or medical Treatment that does not require an overnight Hospital stay are performed by a Physician. The facility must:
1) be under the direct supervision of a Physician;
2) provide Treatment by Physicians and/or Medical Professionals; and
3) have written agreements in place with one or more Hospitals to immediately accept patients who develop complications.

An ASC is also known as an outpatient surgery center or a same day surgery center.

Automobile means a self-propelled private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to:
1) a sedan
2) station wagon
3) sport utility vehicle, and
4) a motor vehicle of the pickup, panel, van, camper, or motor home type

Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

Benefit Plan means a policy or other benefit or service arrangement for medical or dental care, or providing accident or health coverage, under any of the following:
1) individual, group or blanket coverage, whether on an insured or self- funded basis;
2) Hospital or medical service organizations;
3) health maintenance organizations;
4) labor-management plans;
5) employee benefit organization plans;
6) association plans; or
7) any other "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended.

Business of the Policyholder means while on assignment by or at the direction of the Policyholder for the purpose of furthering the business of the Policyholder, but does not include any period of time:
1) while the Insured Person is working at his or her regular place of employment;
2) during the course of everyday travel to and from work; or
3) during an authorized leave of absence or vacation.

If an Insured Person's assignment to a location exceeds 365 days, such assignment will be deemed to change the Insured Person's residence and regular place of employment to the new location.

Civil Aircraft means a civilian or public Aircraft which:

1) has an Airworthiness Certificate;
2) is piloted by a person who has:
    a) a current pilot certificate which the appropriate Aircraft category rating for that Aircraft; and
    b) a current medical certificate which is appropriate for the operation of that Aircraft; and
3) is not operated by the militia, or armed forces of any state, national government or international authority.

A Civil Aircraft does not include a Policyholder Aircraft.

Coinsurance means the percentage of the Usual and Customary Charges incurred for Covered Medical Services payable by Us after the Deductible has been satisfied.

Coma, Comatose means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness by external or internal stimulation, as determined by a Physician.

Common Carrier means any air, land or water motorized Conveyance operated under a license for the transportation of fare-paying Passengers, including ridesharing programs. Common Carrier does not include courtesy transportation for which a charge is not made or cruise ships at sea more than 24 consecutive hours or any Conveyance, regardless of whether the Conveyance is licensed that is hired or used for a sport, gamesmanship, contest, or recreational activity. These Conveyances can include, but are not limited to, race cars, bobsleds, hunting vehicles, sightseeing vehicles, helicopters, fishing boats, parasails, paragliders, and boat cruises operating beyond 12 hours.

Complications of Pregnancy means any condition, whether or not a pregnancy is terminated, that requires Hospital Confinement and whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. Examples include: acute nephritis; cardiac decompensation; disease of the endocrine, hemopoietic, nervous or vascular systems; ectopic pregnancy that is terminated; hyperemesis gravidarum; missed abortion; nephrosis; non-elective caesarean section; spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; or any similar condition(s) of comparable severity.

This definition does not include: elective caesarean section unrelated to a diagnosed complication of pregnancy; false labor; morning sickness; multiple gestation pregnancy; occasional spotting; physician prescribed rest during pregnancy; pre-eclampsia; any similar condition(s) associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy; or any other condition associated with pregnancy but has not been diagnosed by a Physician as a complication of pregnancy as defined.

Confined, Confinement means the assignment to a bed in a medical facility for a period of at least 24 consecutive hours.

Conveyance means any motorized craft, vehicle, or mode of transportation licensed or registered by a governmental authority with competent jurisdiction. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

Covered Accident means an Accident that occurs directly and independently of all other causes while coverage is in effect for an Insured Person resulting in a Covered Loss under the Policy for which benefits are payable.

The Insured Person must be participating in a Covered Hazard, as identified in the Schedule, when the Accident occurs.

Covered Hazard means those hazards set out in the Covered Hazards section of the Schedule, in which Insured Persons are provided insurance under the Policy.

Covered Loss means an accidental death, dismemberment or other Injury covered under the Policy.

Deductible means the amount of Usual and Customary Charges for Covered Medical Services that must be incurred by the Insured Person before benefits become payable. The amount of the Deductible is shown in the Rider Schedule. Benefits are not payable for charges applied to the Deductible.

Dependent Child(ren) means:

1) an Insured Person's or Spouse's natural child, legally adopted child or stepchild;
2) a child placed into the Insure Person's or Spouse's custody for adoption (regardless of whether the adoption has become final);
3) a child for whom the Insured Person or Spouse is ordered by a court or administrative order to provide coverage regardless of whether he/she is the custodial or non-custodial parent; or
4) an Insured Person's or Spouse's foster child or any other child for whom the Insured Person or Spouse has been appointed legal guardian; or
5) any other child who lives with the Insured Person in a regular parent/child relationship and is dependent on the Insured Person for support and maintenance;

who is/are:

1) unmarried; and
2) under 18 years of age; or
3) a student age 18 or older but under age 26.

If an unmarried child is age 18 or older and is:

1) incapable of self-sustaining employment because of a mental or physical disability;
2) chiefly dependent on the Insured Person or Spouse for financial support and maintenance;

and proof has been provided of his/her disability upon Our request, that child will continue to be a dependent child until these conditions cease to exist.

Diagnostic Exams mean any of the following major/advanced tests: angiogram, arteriogram, bone scintigraphy, CT, EEG, EKG, EMG, MRI, PET, SPECT, or thallium stress test. This definition does not include any lab test or x-ray.

Durable Medical Equipment means equipment of a type that is designed primarily for use, and used primarily, by people who are sick (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not sick, even if the items can be used in the Treatment of Emergency Sickness or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Eligible Class means any group of people listed in the Description of Eligible Class(es) shown in the Schedule.

Emergency Room (ER) means a specified area within a Hospital that is designated for emergency healthcare. This area must:

1) be staffed and equipped to handle trauma;
2) be under the direct supervision of a Physician;
3) provide Treatment by Physicians and/or Medical Professionals; and
4) provide care 24 hours per day, 7 days per week.

This definition does not include an Urgent Care Facility.

Emergency Sickness means an illness or disease diagnosed by a Physician which causes a severe or acute symptom that, if not provided with immediate Treatment, would reasonably be expected to result in serious deterioration of the person's health, or place his/her life in jeopardy. Emergency Sickness also includes pregnancy and Complications of Pregnancy.

Experimental or Investigative Treatment means a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the Treatment, device or prescription medication is being used, including any Treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any of those items requiring federal or other government agency approval not received at the time the services are rendered.

Extra-Hazardous Aviation Activity means an Aircraft while it is being used for one or more of the following activities:

1) acrobatics or stunt flying
2) racing or any endurance test
3) crop dusting or seeding
4) spraying
5) exploration
6) pipe or power line inspection
7) any form of hunting
8) bird or fowl herding
9) aerial photography or banner towing
10) any test or experiment
11) firefighting
12) any flight which requires:
    a) a special permit; or
    b) waiver

from the FAA, even though granted.

FAA means:

1) the Federal Aviation Administration of the United States; or
2) the similar aviation authority for the country of the Aircraft's registry, if the country is recognized by the United States.

Geographic Area means the city, providence or region in which the service, procedure, devices, drugs, Treatment or supplies are provided or a greater area, if necessary, to obtain a representation cross-section of charges for a like treatment, service, procedure, device, drug, or supply. Inside the United States, this would be based on the first three digits of the zip code.

Home Health Care means healthcare services provided by a Home Health Care Agency in the residence of an Insured Person, including, but not limited to, counseling services, home health aide services, Hospice Care, skilled nursing care, medical social services and Therapy Services. Services must be rendered under a plan of care that is established and reviewed regularly by a Physician.

Home Health Care Agency means an appropriately licensed home health care agency which:

1) is primarily engaged in providing home health services;
2) provides services under the supervision of a Physician or Medical Professional;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) maintains clinical records on all patients.

Hospice Care means specialized care, medical services and emotional support for an Insured Person who is in the last stages of an advanced illness, focusing on comfort and quality of life rather than cure.

Hospice Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides Hospice Care and related services 24 hours per day, 7 days per week;
2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times; and
3) is not mainly a place for care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Hospice Facility must follow certification by a Physician or hospice medical director that an Insured Person is terminally ill with less than 6 months to live if the Covered Loss runs its normal course. This definition does not include a nursing home, Rehabilitation Facility, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Hospital means an institution which:

1) operates pursuant to law;
2) primarily and continuously provides Medical Care and Treatment of sick and injured persons on an inpatient basis;
3) operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
4) provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof, which is used primarily as:

1) a nursing home, convalescent home or Skilled Nursing Facility;
2) an alcohol or drug treatment facility; or
3) a place for rest, custodial care or for the aged.

Hospital also includes a duly licensed State tax-supported institution, regardless of whether it has an operating room or related equipment for the performance of surgery.

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, mother-in-law, father-in-law, parent (includes step-parent), grand-parent (includes step grand-parent), brother or sister (includes stepbrother or stepsister and half-brother or half-sister), or child (includes a child legally adopted or a child placed for adoption but not yet adopted), or stepchild.

Injury means bodily injury sustained by an Insured Person caused from a Covered Accident that:

1) occurs while the Policy is in force as to the Insured Person whose Injury is the basis of claim; and
2) occurs under the circumstances described in a Covered Hazard applicable to that Insured Person.

See the Schedule for applicability of all Covered Hazards and benefits. All Injuries sustained by one Insured Person in any one Covered Accident, including all related conditions and recurrent symptoms of the Injuries are considered a single Injury.

Inpatient means an Insured Person who is Confined and charged by a medical facility for room and board or is being held in a Hospital for a period of 24 consecutive hours or more. The requirement that an Insured Person be charged by the medical facility does not apply to Confinement in a Veteran's Administration Hospital or other Federal Government Hospital.

Institution of Higher Learning includes, but is not limited to, any state or private university or college, professional or trade school.

Insured Person means a person:

1) who is a member of an Eligible Class described in the Schedule;
2) for whom premium has been paid; and
3) while covered under the Policy.

Intensive Care Unit (ICU) means a specifically designated area of a Hospital that provides the highest level of Medical Care and:

1) is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
2) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
3) is permanently equipped with special lifesaving equipment and medical apparatus for the care of the critically ill or injured;
4) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a 24 hour basis; and
5) has a Physician assigned to the unit on a full-time basis.

An Intensive Care Unit may include Hospital units with the following (or similar) names: burn unit; critical care unit; neonatal intensive care unit; cardiac care unit; or transplant unit.

An Intensive Care Unit is not any of the following step-down units: intermediate care unit; modified/moderate care unit; Observation Unit; progressive care unit; or sub-acute intensive care unit.

This definition does not include a private monitored room.

Kidnap, Kidnapped, or Kidnapping means the wrongful abduction and holding under duress or by fraudulent means of an Insured Person by any person or group making a ransom demand or series of ransom demands for the release of such Insured Person.

Leased Aircraft means any Aircraft not owned by the Policyholder but:

1) furnished for the use of and at the discretion of the Policyholder;
2) under the Policyholder's care, custody, or control for a stated period of time other than for a specific purpose or trip;
3) subject to a formal written lease agreement defining:
   a) all terms, conditions, and obligations of both parties during the term of the lease; and
   b) provisions for the safe return of the Aircraft to the owner, fair wear and tear expected;
4) with or without a pilot or crew furnished by the owner in attendance; and
5) with or without maintenance furnished by the owner.

Medical Care means necessary:

1) medical or surgical Treatment, services and supplies;
2) Hospital, nursing and ambulance services.

Each item of Medical Care must be:

1) prescribed by a Physician;
2) for the sole purpose of treating the Injury.

Medical Emergency Evacuation means, if warranted by the severity of the Insured Person's Injury or Emergency Sickness:

1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained;
2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local Hospital or other medical facility; or
3) both 1) and 2) above.

A Medical Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

Medically Necessary or **Medical Necessity** means a determination by the Insured Person's Physician that Treatment, service or supply provided to treat an Injury is:

1) appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity the level of care needed to provide safe, adequate, and appropriate treatment of the Injury;
2) is commonly accepted as proper care or Treatment of the Injury in accordance with the medical practices of the United States and federal guidelines;
3) can reasonably be expected to result in or contribute to the improvement of the Injury; and
4) is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition of the Injury or the quality of the Medical Care provided.

The fact that a Physician may prescribe, order, recommend, or approve a treatment, service or supply does not, of itself, make the treatment, service, or supply medically necessary for the purpose of determining eligibility for coverage under the Rider.

The Medical Professional must be acting within the scope of his/her license. A Medical Professional does not include an Insured Person or any Immediate Family Member.

Medical Professional means a person who is appropriately licensed to provide Medical Care and Treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional does not include an Insured Person or any Immediate Family Member.

Member of the Household means a person who maintains residence at the same address as the Insured Person at the time of the Injury.

Mental and Nervous Disorders means any condition, disease or disorder listed as a mental or nervous disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), where improvement can be reasonably expected with therapy.

This definition does not include conditions, diseases or disorders related to Substance Abuse.

Military Transport Aircraft means a transport Aircraft operated by:

1) the United States Air Mobility Command (AMC); or
2) a national military air transport service of any country.

Observation Unit means a specified unit within a Hospital, apart from an Emergency Room (ER), where a patient can be monitored by a Physician or Medical Professional following Treatment in an ER or as an Outpatient. This area must:

1) be under the direct supervision of a Physician;
2) provide Treatment by Physicians and/or Medical Professionals; and
3) provide care 24 hours per day, 7 days per week.

Outpatient means an Insured Person who receives Treatment or services at a Hospital, Ambulatory Surgery Center (ASC), lab, medical clinic, Physician or Medical Professional's office/clinic, radiologic center or other licensed medical facility and is neither Confined nor charged for room and board.

Paralysis means the complete loss of muscle function in a part of the body as a result of neurological damage, as determined by a Physician.

Passenger(s) means a person not performing as a pilot, operator, or crew member of a Conveyance.

Permanently Disabled or Permanent Disability means the Insured Person is Totally Disabled and expected to remain Totally Disabled for the remainder of his or her lifetime.

Physician means a provider or practitioner who:

1) is properly licensed or certified to provide care or Treatment under the laws of the state where he or she practices;
2) provides services that are within the scope of his or her license or certificate; and
3) is not the Insured Person, a Member of the Household of the Insured Person or an Immediate Family Member.

Policy means this insurance policy, certificate, the Schedule and all attached riders, amendments, endorsements or other papers.

Policy Period means the period between the Policy Effective Date and Policy Termination Date. These dates are shown on the Schedule.

Policyholder Aircraft means an Aircraft which is owned by the Policyholder, a Leased Aircraft or an Aircraft operated by or on behalf of the Policyholder.

Pre-existing Condition means a health condition for which an Insured Person has sought or received medical advice or Treatment from a Physician or Medical Professional at any time during the , 12 months immediately preceding the Policy Effective Date of coverage under the Policy. Any exclusion related to an Injury that results from, or is caused or contributed to by, a Pre-existing Condition shall only exclude coverage for such condition during the first 12 months after the Insured Person's Effective Date.

Rehabilitation Care Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides Rehabilitation Care Services;
2) is under the direct supervision of a Physician;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a rehabilitation care facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Relocation Trip means a trip which:

1) begins when the Insured Person or his or her Spouse or Dependent Child(ren) leave his or her former place of residence for the purpose of relocating to a new residence; and
2) ends when he or she arrives at his or her new place of residence;

provided such trip is due to the Insured Person's relocation which is at the request and expense of the Policyholder.

A Relocation Trip will not include any period of time in excess of 7 days of the Relocation Trip during which the Insured Person or his or her Spouse or Dependent Child(ren) take a vacation or Sojourn and/or Personal Deviation which substantially differs from the Relocation Trip.

Schedule means the benefits, benefit amounts, terms, limitations, and provisions of coverage selected by the Policyholder which is attached to and made a part of the Policy.

Sickness means an illness, disease or condition that impairs an Insured Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident. Sickness also includes pregnancy and Complications of Pregnancy.

Skilled Nursing Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides skilled nursing care and related services 24 hours per day, 7 days per week;
2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Skilled Nursing Facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Rehabilitation Care Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Sojourn and/or Personal Deviation means non-business travel or activities undertaken while on the Business of the Policyholder, or during a Business Trip, but unrelated to furthering the Business of the Policyholder.

Spouse means any individual who is recognized as the spouse of the Insured Person, under applicable state law.

Spouse will also include a domestic partnerdomestic partner or civil union partner as determined by any controlling legal authority or, in the absence of such authority, by agreement between Us and the Policyholder.

Surgical Replantation means the surgical reattachment of an arm, leg, hand, foot, finger, or toe that has been severed from an Insured Person's body.

Therapy Services means acupuncture, respiratory therapy, occupational therapy, physical therapy or speech therapy.

Totally Disabled or Total Disability means the Insured Person is unable to perform the material and substantial duties of any occupation for which he or she is qualified by reason of education, experience or training.

Transportation means moving an individual by the most efficient and available land, water or air Conveyance.

Treatment means medical advice, diagnosis, care or services (including diagnostic measures) received by a person, or the use of drugs or medicines by a person.

Trip means a trip taken by an Insured Person which begins when the Insured Person leaves his or her residence or place of regular employment for the purpose of going on the trip (whichever occurs last), and is deemed to end when the Insured returns from the trip to his or her residence or place of regular employment (whichever occurs first). However, the trip is deemed to exclude any period of time during which the Insured Person is on an authorized leave of absence or vacation or travel to and from the lnsured Person's place of regular employment. This definition does not include the lnsured Person's trip to a location that extends for more than 365 days. Such a trip will be deemed to change the lnsured Person's residence or place of regular employment to the new location.

Urgent Care Facility means a licensed, freestanding healthcare facility providing immediate, short-term Medical Care without an appointment, other than a Hospital (including any outpatient department of a Hospital), Emergency Room, or Physician or Medical Professional's office/clinic. The facility must:

1) be under the direct supervision of a Physician; and
2) provide Treatment by Physicians and/or Medical Professionals.

Usual and Customary Charge(s) 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.

Violent Act means any willful or unlawful use of force in connection with the commission of or the attempt to commit a crime (including, but not limited to, robbery, hold-up, extortion, theft, Kidnapping, hostage-taking, assault, battery, sniping, murder, manslaughter, riot, or insurrection) that:

1) results in Injury to the Insured Person; and
2) is a felony or a misdemeanor in the jurisdiction in which it occurs.

We, **Us** or **Our** means the Hartford Fire Insurance Company.

POLICY EFFECTIVE AND TERMINATION DATES

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the Schedule at 12:01 AM Standard Time at the address of the Policyholder where this Policy is delivered.

Policy Termination Date. We may terminate this Policy by giving 45 days advance notice in writing to the Policyholder. Either We or the Policyholder may terminate this Policy on any premium due date by giving 45 days advance notice in writing to the other party.

This Policy may, at any time, be terminated by mutual written consent of the Policyholder and Us.

This Policy terminates automatically on the earlier of:

1) the Policy Termination Date shown in the Schedule; or
2) the end of the Grace Period if premiums are not paid when due.

Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of termination.

INSURED PERSON'S EFFECTIVE AND TERMINATION DATES

Insured Person's Effective Date. An Insured Person's coverage under the Policy begins on the latest of:

1) the Policy Effective Date;
2) the date for which the first premium for the Insured Person's coverage is paid; or
3) the date the person becomes a member of an Eligible Class as described in the Schedule.

A change in an Insured Person's coverage under the Policy due to a change in his or her Eligible Class, or Covered Hazard becomes effective on the later of:

1) when the change in his or her Eligible Class, or Covered Hazard occurs; or
2) if the change requires a change in premium, the date the changed premium is paid.

However, a change in coverage applies only with respect to a Covered Loss that occurs once the change becomes effective.

Insured Person's Termination Date. An Insured Person's coverage under the Policy ends on the earliest of:

1) the date the Policy is terminated (unless the Policyholder and Us agree, in writing, to permit coverage to continue to the end of the period for which premiums have been paid in lieu of a return of unearned premiums);
2) the end of the Grace Period if premiums are not paid when due; or
3) the date the Insured Person ceases to be a member of any Eligible Class described in the Schedule.

Termination of coverage will not affect a claim for a Covered Loss that occurs either before or after such termination if that loss results from a Covered Accident that occurred while the Insured Person's coverage was in force under the Policy.

LIMITATIONS AND EXCLUSIONS

Economic Sanction
We will not provide coverage or pay benefits under the Policy to the extent, and only to the extent, that We are prohibited from providing coverage or making payment by any type of travel restriction, trade restriction, economic sanction, or embargo imposed by the United States government.

Limitation on Multiple Benefits
If an Insured Person suffers one or more Covered Losses from the same Covered Accident for which amounts are payable under all of the benefits provided by the Policy, the maximum amount payable under all of the benefits combined will not exceed the largest amount payable for one of those Covered Losses.

Limitation on Multiple Covered Hazards or Classes
If an Insured Person's Injury is caused by a Covered Accident that occurs while the Insured Person is covered under more than one Covered Hazard or Class, and if the same benefit applies to that Insured Person with respect to more than one such Covered Hazard or Class, then the Accidental Death or Accidental Dismemberment Principal Sum for that Insured Person for that Covered Accident will be determined as though the Covered Accident occurred while the Insured Person was covered under only one such Covered Hazard and Class. We will pay the benefits for the Covered Hazard and Class with the largest Principal Sum for that Insured Person.

Aggregate Limit
The Accidental Death or Accidental Dismemberment Principal Sum otherwise payable shall be reduced if more than one Insured Person suffers a loss as a result of the same Covered Accident, and if amounts are payable for those losses under all of the benefits provided by the Policy.

Exclusions
Unless otherwise specified in the Policy, including any attached Riders, the Policy does not cover loss resulting from or for:

1) suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted Injury;
2) war or act of war, whether declared or undeclared (not including acts of terrorism);
3) Injury sustained 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 Service is not excluded, unless it extends beyond 31 days;
4) Injury sustained while on any Aircraft except a Civil Aircraft, or Military Transport Aircraft, unless specifically covered by a Hazard Rider;
5) except when specifically covered by a Hazard Rider, Injury sustained while on any Aircraft:
    a) as a pilot, crewmember or student pilot;
    b) as a flight instructor or examiner;
    c) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization covering any Eligible Class under the Policy; or
    d) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
6) Injury sustained while under the influence of any narcotics, drug or controlled substance, unless administered by or taken according to the instruction of a licensed Physician (This exclusion does not apply to benefits that are payable for hospital, medical, or surgical expenses);
7) Injury sustained as a result of the Insured Person's voluntary intoxication through the use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;
8) Injury sustained by an Insured Person during or as a result of his or her commission of a felony or while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;
9) Injury sustained while the Insured Person is under the influence of intoxicants (as defined by the law of the jurisdiction in which the Injury occurred) while operating any vehicle or means of Transportation or Conveyance (This exclusion does not apply to benefits that are payable for hospital, medical, or surgical expenses);
10) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;

11) sickness, disease, or bacterial or viral infection, or medical or surgical treatment thereof unless and only to the extent covered by Rider, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
12) Mental and Nervous Disorders;
13) services for which no charge is normally made; or
14) Injury sustained while playing or practicing in:
    a) all intercollegiate sports;
    b) any inter-school club sports;
    c) any intramural sports; or
    d) any form of tackle football.

    Any sports activity that is sponsored by the Policyholder is not included in this exclusion.

HAZARDS

Hazard H-1: 24-Hour Accident Protection Business and Pleasure Hazard

We will pay the Policy benefits for the Hazard described in the Rider when an Insured Person suffers an Injury anywhere in the world resulting from a Covered Loss any time while insured by the Policy and while the Insured Person is:

1) a Passenger on, boarding, or alighting from a Civil Aircraft or Military Transport Aircraft;
2) being struck or run down by an Aircraft;
3) operating or a Passenger on, boarding, alighting from, or being struck or run down by any Conveyance being used as a means of Transportation.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

Hazard H-3: 24-Hour Accident Protection While on Business Hazard

We will pay the Policy benefits for the Hazard described in the Rider when an Insured Person suffers an Injury resulting from a Covered Loss during a Trip and while on the Business of the Policyholder, not lasting for more than 365 days, including an Injury while:

1) operating or a Passenger on, boarding, alighting from, or being struck or run down by any Conveyance being used as a means of land or water Transportation, except:
    a) any such Conveyance the Insured Person has been hired to operate or for which the Insured Person has been hired as a crew member and while the Insured Person is performing as an operator or crew member on any such Conveyance; or
    b) any such Conveyance the Insured Person is operating, or for which the Insured Person is performing as a crew member, (including while on, boarding, alighting from, or being struck or run down by) for the Transportation of Passengers or property for hire, profit or gain; or
2) a Passenger on, boarding, or alighting from a Civil Aircraft or Military Transport Aircraft; or
3) being struck or run down by an Aircraft.

The benefits under the Rider also apply where the Sojourn or Personal Deviation involves one or more stops en route to the destination, and extensions time spent at the destination, that do not last longer than a total of 14 days.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

Hazard H-4: 24-Hour Accident Protection While on a Policyholder Aircraft for Passenger and Pilot and Crew Hazard

We will pay Policy benefits for the Hazard described in the Rider, if an Insured Person suffers an Injury as a result of a Covered Loss anywhere in the world during a Trip on the Business of the Policyholder:

1) if the Insured Person is operating or a Passenger on, boarding, alighting from, or being struck or run down by the Policyholder Aircraft, specified below, while such Insured Person
   a) is a Passenger; or
   b) is acting or training as a pilot, specified below, or crew member by or on behalf of the Policyholder, but only if such Insured Person is certified and licensed by a governmental authority with competent jurisdiction to operate or serve as a pilot or crew on such Policyholder Aircraft; or
2) due to any Passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

For purposes of the Rider, only the following Insured Person(s) are authorized as pilot(s):

Jim Murray, Chris Hutchins, Jon Middleton, David Vanderford, Allen Fausch , Ken Wiseman, John Gaines, Tyler Shirley, Daniel Krause or any additional pilot who is hired by the Policyholder to pilot such aircraft, holding a current and valid certificate of competency of a rating authorizing him or her to pilot this aircraft and who has logged a minimum of 1500 hours as a pilot, at least 500 hours of which were logged in a single or multi-engine aircraft of like and basic design.

The above named pilot(s) must have a current and valid medical certificate and pilot certificate with a proper rating to fly such Aircraft.

The Policyholder Aircraft(s) covered by the Rider are:

N120CL Cessna Citation Latitude 2016, N121CL Cessna Citation Latitude 2016, N106ST - Cessna XLS+ 2013 model, N303ST - Cessna XLS+ 2013 model

Newly Acquired Aircraft Coverage: The Policyholder Aircraft Passenger and Pilot and Crew Hazard shall apply to any Newly Acquired Aircraft from the date such Aircraft is delivered to the Policyholder, provided the Policyholder:

1) notifies Us within 30 days; and
2) pays any required premium for such coverage.

Substitute and Replacement Aircraft Coverage: The Policyholder Aircraft Passenger and Pilot and Crew Hazard shall apply to any Substitute Aircraft or Replacement Aircraft from the time such Aircraft is used as a temporary substitute by the Policyholder, provided the Policyholder Aircraft covered under the Policy is withdrawn from use due to its breakdown, repair, servicing, loss, or destruction.

RIDER SCHEDULE

Aggregate Limit: $3,500,000

LIMITATIONS AND EXCLUSIONS
This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity. The following exclusions in the Policy do not apply to the Rider to the extent the Rider specifically covers them:

1) Injury sustained while on any Aircraft except a Civil Aircraft, or Military Transport Aircraft;
2) Injury sustained while on any Aircraft:
   a) as a pilot, crew member or student pilot;
   b) as a flight instructor or examiner;
   c) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization covering any Eligible Class under the Policy; or
   d) being used for tests, experimental purposes, stunt flying, racing or endurance tests.

Hazard H-7: 24-Hour Family Relocation Trip Hazard

We will pay the Policy benefits for the Hazard described in the Rider when an Insured Person‘s Spouse or Dependent Child(ren) suffer(s) an Injury as a result of a Covered Loss which occurs anywhere in the world during a Relocation Trip.

A Relocation Trip will not include any period of time in excess of 7 days during which the Insured Person takes a vacation, or a Sojourn or Personal Deviation from the Relocation Trip.

Hazard H-8: 24-Hour Hijacking or Sky-jacking Business Hazard

We will pay the Policy benefits for the Hazard described in the Rider when an Insured Person suffers an Injury resulting from a Covered Loss which occurs during a Hijacking or Sky-jacking anywhere in the world while the Insured Person is on a Tripon the Business of the Policyholder . Coverage under the Rider shall continue while the Insured Person is subject to the control of the hijacker(s) and during travel directly to his or her residence or original destination.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

Hazard H-15: Commutation Hazard

EXTRAORDINARY COMMUTATION HAZARD
We will pay the Policy benefits for the Hazard described in the Rider, for an Injury which occurs while the Insured Person is commuting directly between his or her residence and place of regular employment:

1) by Automobile or other Conveyance not normally used by the Insured Person for commuting; and
2) during a strike, power failure, major breakdown, or similar event which results in the discontinuance or interruption of one or more public transportation systems regularly used by the Insured Person;

on a regularly scheduled workday.

Hazard H-21: Family Travel Hazard

We will pay the Policy benefits for the Hazard described in the Rider when the Spouse or Dependent Child(ren) of the Insured Person suffer(s) an Injury resulting from a Covered Loss:

1) while accompanying the Insured Person or on his or her way to join the Insured Person on a Trip while on the Business of the Policyholder, including a Sojourn or Personal Deviation taken during the course of such Trip; and
2) when such Trip is authorized by and/or paid for in whole or in part by the Policyholder.

Benefits payable under this Hazard are subject to the Exclusions listed in the Policy.

Hazard H-26: Non-Employee Directors or Trustee Business Travel Hazard

We will pay the Policy benefits for the Hazard described in the Rider, if an Insured Person suffers an Injury as a result of a Covered Loss while:

1) traveling to, at, or returning from the Policyholder's board of directors' or board of trustees' meetings, at the Policyholder's authorization, direction and expense;
2) on a Trip on the Business of the Policyholder; or
3) on a Relocation Trip.

Coverage under the Rider begins when the Insured Person leaves his or her residence or place of regular employment, whichever occurs last and ends when the Insured Person returns to his or her residence or place of regular employment, whichever occurs first.

Hazard H-32: On Premises Violent Act Hazard

We will pay the Policy benefits for the Hazard described in the Rider, if an Insured Person suffers an Injury as a result of a Violent Act that occurs while On the Premises of the Policyholder and while the Insured Person is covered under the Policy.

This Hazard will not apply to a Covered Loss that results from a Violent Act committed by:

1) the Insured Person;
2) the Insured Person's Immediate Family Member;
3) an employee of the Policyholder;
4) a Member of the Household in which the Insured Person resides; or
5) any Insured Person currently eligible for coverage under the Policy.

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, a police report detailing the Violent Act must be provided.

BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT(S)

If the Insured Person's Injury results in any of the losses listed in the table below within 365 days after the date of the Covered Accident, We will pay the sum shown opposite the loss. We will not pay more than the Accidental Death or Accidental Dismemberment Principal Sum shown for each Insured Person for all losses due to the same Covered Accident. The Accidental Death or Accidental Dismemberment Principal Sum amount is shown in the Schedule.

FOR LOSS OF:	**BENEFIT:**
Life……	100% of the Accidental Death Principal Sum
Both Hands or Both Feet or Sight of Both Eyes……	100% of the Accidental Dismemberment Principal Sum
One Hand and One Foot……..	100% of the Accidental Dismemberment Principal Sum
One Hand and Sight of One Eye …….	10% of the Accidental Dismemberment Principal Sum
One Foot and Sight of One Eye……..	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in Both Ears……..	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in One Ear…….....	75% of the Accidental Dismemberment Principal Sum
One Arm or One Leg…….....	75% of the Accidental Dismemberment Principal Sum
One Hand or One Foot……..	50% of the Accidental Dismemberment Principal Sum
Sight of One Eye…….	50% of the Accidental Dismemberment Principal Sum
Speech or Hearing in Both Ears……	50% of the Accidental Dismemberment Principal Sum
Thumb and Index Finger on the Same Hand……	25% of the Accidental Dismemberment Principal Sum
Hearing in One Ear…….	25% of the Accidental Dismemberment Principal Sum
One Thumb…….	10% of the Accidental Dismemberment Principal Sum

For purposes of this benefit:

1) **Loss of Arm** means Severance of an arm above the elbow joint, including the Severance of the entire arm.
2) **Loss of Both Feet, Loss of One Foot** means Severance of a foot or both feet above the ankle joint, including the Severance of an entire leg or any part of a leg that includes an entire foot.
3) **Loss of Both Hands, Loss of One Hand** means Severance of at least four whole fingers at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand) from one or both hands, including the Severance of an entire arm or any part of an arm that includes an entire hand.
4) **Loss of Fingers or Thumb** means Severance of more than one finger or the thumb at least at or proximal to the first interphalangeal joint of each finger.
5) **Loss of Hearing** means total and permanent loss of hearing in one or both ears which cannot be corrected by any means.
6) **Loss of Leg** means Severance of a leg above the knee joint, including the Severance of the entire leg.
7) **Loss of Sight of Both Eyes, Loss of Sight of One Eye** means total and permanent loss of sight or blindness which cannot be corrected by any means, or Severance of one or both eyes.
8) **Loss of Speech** means total and permanent loss of audible voice communication which cannot be corrected by any means.
9) **Severance** means the complete separation and dismemberment of the part from the body.

Surgical Replantation Benefit
If a limb or appendage is Surgically Replanted, the amount payable will be 50% of the amount which would have been paid for a Loss of such limb or appendage. If the Surgical Replantation fails to provide the person with at least 75% use of the limb or appendage, the Benefit Amount for the Loss will be paid, less any amount paid for the Surgical Replantation.

The amount payable depends on the type of Loss as shown above. All benefits are subject to the Accidental Dismemberment Principal Sum amount shown in the Schedule. We will not pay more than the Accidental Dismemberment Principal Sum shown for each Insured Person for all losses due to the same Covered Accident subject to the Age Reduction Schedule.

Exposure and Disappearance
We will presume an Insured Person has died due to Injuries if, while insurance is in effect, the Insured Person dies as a result of exposure to the elements as a result of an Injury.

We will presume the Insured Person has died if, while insurance is in effect and after the forced landing, stranding, sinking, or wrecking of a vehicle:

1) the Insured Person disappears; and
2) the Insured Person's body is not found within 1 year(s) of disappearance; and
3) a valid death certificate is issued by a court of competent jurisdiction.

Benefit B-2: Accident Medical Expense Benefit

ACCIDENT MEDICAL EXPENSE BENEFIT

If an Insured Person suffers an Injury that, within 180 days of the date of the Covered Accident that caused the Injury, requires him or her to be treated by a Physician, We will pay the Usual and Customary Charges incurred for Covered Medical Services that are Medically Necessary and received due to that Injury, up to the Maximum Amount per Insured Person for all Injuries caused by the same Covered Accident. Benefits are payable for charges incurred within the Maximum Benefit Period shown in the Rider Schedule.

COVERED MEDICAL SERVICES

Covered Medical Services under the Rider are as follows:

1) **Hospital:** the following services provided when the Insured Person is Confined in a Hospital:
   a) the daily room rate for a semi-private room when an Insured Person is Confined in a Hospital and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
   b) ancillary Hospital services and supplies including operating room, laboratory tests, Diagnostic Exams, anesthesia and medicines (excluding take home drugs) when Confined in a Hospital.
   c) the daily room rate when an Insured Person is Confined in a Hospital in a bed in the Intensive Care Unit and nursing services other than private duty nursing services.
2) **Private Duty Nurse:** private duty nursing services by a registered nurse (RN) or licensed practical nurse (LPN) while an Insured Person is Confined in a Hospital. These services must be ordered by a Physician.
3) **Emergency Room:** expenses incurred within 72 hours of a Covered Accident due to Treatment in an Emergency Room. Such expenses include the attending Emergency Room Physician's charges, x-rays, laboratory procedures, medications, use of the Emergency Room, and medical supplies.
4) **Prosthesis:** artificial limbs, eyes, larynx, or other prosthesis for initial acquisition and fitting. We will not pay for repair or replacement of any prosthesis, unless due to a Covered Accident.
5) **Ambulatory Surgical Center or Ambulatory Medical Center:** Treatment including operating room, laboratory tests, anesthesia, medical supplies, and medicines (excluding take home drugs) provided in an Ambulatory Surgical Center or Ambulatory Medical Center.
6) **Physician:** expenses for Treatment provided by a Physician.
7) **Anesthesia:** expenses for pre-operative screening, anesthetics, and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis.
8) **Durable Medical Equipment Rental:** expenses for rental of a wheelchair, orthopedic appliances, orthopedic braces, or other medical equipment that has therapeutic value for an Insured Person. We will not cover computers, motor vehicles, or modifications to a motor vehicle, ramps and installation costs, eyeglasses, and hearing aids. No benefits will be paid for rental charges in excess of the purchase price.
9) **Blood and Blood Products:** expenses for blood, blood products, artificial blood products, and transfusions of any blood or blood products.
10) **Ambulance:** expenses for transportation from the emergency site to the Hospital.
11) **Radiological Procedures:** Outpatient expenses for CAT Scan, MRI, x-ray, CT, PET, ultrasound, and other radiological procedures. Does not include dental x-rays.

12) **Outpatient Laboratory Tests:** expenses for laboratory tests provided when the Insured Person is not Confined in a Hospital and provided by a medical facility other than an Emergency Room or Ambulatory Surgical Center.
13) **Prescription Drug:** expenses for drugs prescribed by a Physician for the Treatment of Injury and administered on an outpatient basis.
14) **Rehabilitation Care Facility:** expenses for physical and occupational rehabilitation. Treatment must be provided in a duly licensed Rehabilitation Care Facility and be under the direction of a Physician.
15) **Dental:** expenses including dental x-rays for the repair or Treatment of each Injured tooth that is whole, sound, and a natural tooth at the time of the Covered Accident.
16) **Vision or Hearing Products:** eyeglasses, contact lenses, and hearing aids when damage occurs in a Covered Accident that requires medical Treatment.
17) **Skilled Nursing Facility:** expenses for Confinement in a Skilled Nursing Facility if it begins within 5 consecutive days after an Insured Person is Confined in a Hospital as a result of a Covered Accident. We will pay for Treatment if a Physician visits the Insured Person at least once every 30 days and certifies that the Confinement is Medically Necessary.
18) **Home Health Care:** expenses for Home Health Care beginning within 5 consecutive days after discharge from a Hospital, Skilled Nursing Facility, or Rehabilitation Care Facility.
19) **Chiropractic Care**: expenses for Treatment and services received by a chiropractor.
20) **Physical and Occupational Therapy**: expenses for physical or occupational therapy and an office visit connected with any such service.

RIDER SCHEDULE

ACCIDENT MEDICAL EXPENSE (Class 2 only)

Maximum Amount per Insured Person:	$10,000
Deductible:	$0 per Covered Accident
Coinsurance:	100% of Usual and Customary Charges
Maximum Benefit Period:	52 weeks from the date of the Covered Accident

LIMITATIONS AND EXCLUSIONS

Rider Exclusions
Unless otherwise specified in the Rider, in addition to the exclusions in the Policy, We will not pay Accident Medical Expense Benefits for any loss, Treatment, or services resulting from, or contributed to, by:

1) pregnancy, childbirth, elective abortion, an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
2) Complications of Pregnancy or miscarriage, except as a result of a Covered Accident;
3) elective or cosmetic surgery, except for reconstructive surgery needed as the result of an Injury;
4) orthopedic appliances used mainly to protect an Injury, so the Insured Person can participate in interscholastic, intercollegiate or club sports;
5) Treatment or service provided by a private duty nurse;
6) routine physical exams and medical services or wellness visits;
7) overuse symptoms including, but not limited to, bursitis, tendonitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, malfunctions of the heart, embolism, reinjuries or the aggravation thereof, sprains, hernia, strains, muscle tears, or repetitive motion Injury, and/or Treatment of Injuries that result over a period of time (such as blisters, tennis elbow, etc.) except as specifically provided in the Rider;
8) aggravation or re-Injury of a Pre-existing Condition;
9) Injury for which expenses are incurred that are in excess of Usual and Customary Charges for Covered Medical Services, or expenses that are not covered;
10) Mental and Nervous Disorders;
11) Medical Emergency Evacuation;
12) Experimental or Investigative Treatment or procedures;

13) an occupational Injury for which services or supplies for the Treatment thereof are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

Benefit B-4: Adaptive Home & Vehicle Benefit

If an Insured Person suffers an Injury, other than loss of life, that results in a loss payable under the Accidental Dismemberment or Paralysis Benefit, We will pay an additional benefit that is the lesser of:

1) the Benefit Amount as indicated in the Rider Schedule; or
2) the actual cost

for Home Alteration and Vehicle Modification Expenses that are incurred within 24 months of the date of the Covered Accident that caused the Injury if an Insured Person:

1) did not require, prior to the date of the Covered Accident that caused the Injury, the use of a wheelchair or other adaptive device to be ambulatory; and
2) as a direct result of such Injury, the use of a wheelchair or other adaptive device to be ambulatory is now compulsory.

This benefit will be payable only if:

1) such Home Alterations are:
    a) made by a person(s) with experience in such alterations; and
    b) recommended by a recognized organization providing support and assistance to wheelchair or other adaptive device users; and
2) such Vehicle Modifications are:
    a) carried out by a person(s) with experience in Vehicle Modifications; and
    b) approved by the motor vehicle department of the state.

Benefit B-7: Bereavement Counseling Benefit

If the Insured Person suffers an accidental death or an accidental dismemberment or Paralysis or an accidental loss of use for which an Accidental Death, or Accidental Dismemberment or Paralysis Benefit is payable under the Policy or if he or she goes into a Coma for which a Coma Benefit is payable, We will pay the Bereavement Counseling Benefit if an Insured Person or his or her Spouse and/or Dependent Child(ren) receives Bereavement Counseling.

We will pay the Bereavement Counseling Benefit Amount for each Bereavement Counseling session he or she attends, up to the Maximum Number of Sessions as found in the Rider Schedule.

Bereavement Counseling sessions must first begin within 365 days after the date of the Covered Accident. Benefits for any Bereavement Counseling session must be incurred within 1-3 years after the date of the Insured Person's Covered Accident.

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, evidence of expenses incurred for services provided for Bereavement Counseling is required in order to receive benefits under the Rider.

Benefit B-13: Coma Benefit

If an Injury renders the Insured Person Comatose within 365 days of the date of the Covered Accident, and if the Coma continues for a period of 30 consecutive days, We will pay a monthly benefit equal to the Maximum Benefit Amount shown in the Rider Schedule. No benefit is provided for the first 30 days of the Coma.

The benefit is payable monthly as long as the Insured Person remains Comatose due to the Injury, but ceases on the earliest of:

1) the end of the month in which the Insured Person dies;
2) the end of the month in which the Insured Person recovers from the Coma;
3) the end of the month in which the Monthly Benefit Period ends; or
4) the total payments equal the Maximum Benefit Amount.

We will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which We are liable when the Insured Person is Comatose for less than a full month.

If an Insured Person is in a Coma for which the Monthly Benefit Amount is payable and dies within 365 days after the Covered Accident, We will pay a lump sum equal to the Insured Person's Maximum Benefit Amount, less any benefit amount for Coma already paid.

We reserve the right, at the end of the first 30 consecutive days of Coma and as often as We may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Insured Person is Comatose, including, but not limited to, requiring an independent medical examination provided at Our expense.

Benefit B-21: Education Expense Benefit

If an Insured Person suffers a loss of life for which an Accidental Death Benefit is payable under the Policy, We will pay the following benefit(s):

Spouse Education

We will pay a benefit to or on behalf of the Spouse of the Insured Person who meets the definition of Spouse on the date of the Covered Accident causing the lnsured Person's death and on the date of the lnsured Person's death and who, for the purpose of obtaining an independent source of support or to enrich his or her ability to earn a living:

1) is enrolled in any Institution of Higher Learning or professional or trade training program on the date of the lnsured Person's death; or
2) subsequently enrolls in an Institution of Higher Learning or professional or trade training program within 30 months after the date of the lnsured Person's death.

The benefit will be paid for each year of the Spouse's continuous enrollment in an Institution of Higher Learning or professional or trade training program, to a maximum of four (4) consecutive years.

The total amount of the benefit each year is equal to the least of:

1) the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for the Spouse;
2) the Percentage of Principal Sum shown in the Rider Schedule based on the Insured Person's Principal Sum on the date of the Covered Accident; or
3) the Maximum Annual Amount shown in the Rider Schedule.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment and payment for that term.

A Spouse who ceases to be enrolled as described above becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment that begins before the date of the lnsured Person's death.

RIDER SCHEDULE

Spouse Education:

	Percentage of Principal Sum	Maximum Annual Amount
Classes 1,2,3,4 & 5	5% of Principal Sum	$25,000

Benefit B-32: Medical Emergency Evacuation Benefit

MEDICAL EMERGENCY EVACUATION BENEFIT

We will pay for Covered Medical Emergency Evacuation Expenses reasonably incurred if the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Medical Emergency Evacuation while he or she is outside a 100 mile radius from his or her current place of primary residence, up to the Maximum Benefit Amount shown in the Rider Schedule for all Medical Emergency Evacuations due to all Injuries from the same Covered Accident or all Emergency Sicknesses from the same or related causes.

Benefits will not be payable, unless:

1) the Physician ordering the Medical Emergency Evacuation certifies that the severity of the Insured Person's Injury or Emergency Sickness requires a Medical Emergency Evacuation;
2) all Transportation arrangements made for the Medical Emergency Evacuation are by the most direct and economical method and route possible;
3) the charges incurred are Medically Necessary, and do not exceed the usual level of charges for similar Transportation, Treatment, services, or supplies in the locality where the expense is incurred; and
4) the charges incurred do not include charges that would not have been incurred if no insurance existed.

FAMILY TRAVEL BENEFIT

Following an Insured Person's Medical Emergency Evacuation, We will pay for expenses reasonably incurred:

1) to return to their current place of primary residence, the Insured Person's Spouse and any of the Insured Person's Dependent Children who were accompanying the Insured Person when the Medical Emergency Evacuation became necessary, with an attendant for the Dependent Children if necessary and if the Dependent Children are not accompanied by the Spouse; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person;
2) for lodging and meals for up to 10 days for the Insured Person's Spouse and Dependent Children in the area where the Insured Person is Confined, if:
   a) they were accompanying the Insured Person when the Medical Emergency Evacuation became necessary; and
   b) the place of Confinement is outside a 100 mile radius from the Insured Person's place of primary residence.

   We will only pay for such expenses for days in excess of the days that had been planned for the trip prior to the Insured Person's Medical Emergency Evacuation, and only while he or she remains so Confined. We will not pay for such expenses in excess of, for the Spouse and Dependent Children combined, $100 per day for lodging and $50 per day for meals;
3) to bring one person chosen by the Insured Person to and from the Hospital or other medical facility where the Insured Person is Confined if:
   a) the Insured Person is alone; and
   b) the place of Confinement is outside a 100 mile radius from the Insured Person's place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket; and
4) for lodging and meals for up to 10 days for such person in the area of such place of Confinement, but:
   a) only while the Insured Person remains so Confined; and

b) not to exceed $100 per day for lodging and $50 per day for meals.

LIMITATIONS AND EXCLUSIONS

Our designated travel assistance provider must make all arrangements and must authorize all expenses in advance of any benefits being payable. Benefits will not be payable unless We authorize in writing, or by authorized electronic or telephonic means, all expenses in advance, and services are rendered by Us or Our designated travel assistance provider. We reserve the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Us in advance. In the event the Insured Person refuses to be evacuated, We will not be liable for any expenses incurred after the date medical evacuation is recommended.

Benefit B-39: Paralysis Benefit

We will pay the percentage of the Maximum Benefit Amount shown below if Injury to the Insured Person results in any one of the types of loss(es) specified below within 365 days of the date of the Covered Accident that caused the Injury, provided that the Paralysis is diagnosed by a Physician as reasonably expected to continue for the duration of his or her lifetime.

If an Insured Person dies within 365 days of the Covered Accident, then We will pay a lump sum equal to the Insured Person's Maximum Benefit Amount shown in the Rider Schedule, less any Benefit Amount for Paralysis already paid.

RIDER SCHEDULE

	Maximum Benefit Amount
Class 1	$500,000
Class 2	$500,000
Class 3	$250,000
Class 4	$250,000
Class 5	$50,000
Class 6	$25,000

Loss	**Classes 1, 2, 3, 4, 5 & 6**
Quadriplegia	100% of the Maximum Benefit Amount
Triplegia	75% of the Maximum Benefit Amount
Paraplegia	75% of the Maximum Benefit Amount
Hemiplegia	50% of the Maximum Benefit Amount
Uniplegia	25% of the Maximum Benefit Amount

LIMITATIONS AND EXCLUSIONS

If an Insured Person suffers a loss for which a benefit is payable under more than one of the following provisions; Accidental Death and Dismemberment Benefit, only one benefit, the one which would pay the largest benefit amount, will be paid.

Benefit B-40: Permanent Total Disability Benefit (Lump Sum)

If the Insured Person, as a result of an Injury, is rendered Permanently Disabled within 365 days of the Covered Accident that caused the Injury, We will pay 100% of the Benefit Amount, as shown in the Rider Schedule, at the end of 12 consecutive months of such Permanent Disability.

We reserve the right, at the end of the first 12 consecutive months of Permanent Disability to determine, on the basis of all the facts and circumstances, that the Insured Person is Permanently Disabled, including, but not limited to, requiring an independent medical examination provided at Our expense.

Benefit B-49: Rehabilitation Expense Benefit

If the Insured Person is participating in a Covered Hazard and suffers a Covered Accident for which an Accidental Dismemberment or Paralysis benefit is payable under the Policy, We will reimburse the Insured Person for Covered Rehabilitative Expenses that result from the Injury causing the dismemberment or Paralysis up to the Maximum Benefit Amount shown in the Rider Schedule for all Injuries caused by the same Covered Accident. The Covered Rehabilitative Expenses must be incurred within 2 years after the date of the Covered Accident causing the Injury.

Benefit B-50: Repatriation of Remains Benefit

REPATRIATION OF REMAINS BENEFIT

If an Insured Person suffers an Injury or Emergency Sickness that results in loss of life while covered under the Policy, We will pay for certain expenses incurred as a result of such death including, but not limited to, the following:

1) the expense incurred for the preparation of the deceased’s body for burial or cremation;
2) the most economical coffin or receptacle adequate for transporting the remains; and
3) transportation of the deceased’s body to the place of burial or cremation;

up to the Maximum Benefit Amount shown in the Rider Schedule below, provided that the death of the Insured Person occurred outside a 100 mile radius from his or her current place of primary residence.

FAMILY TRAVEL BENEFIT

Following an Insured Person's death for which a Repatriation of Remains benefit is payable under the Rider, We will pay for expenses reasonably incurred:

1) to return to their current place of primary residence, the Insured Person's Spouse and any of the Insured Person's Dependent Children who were accompanying the Insured Person when his or her death occurred, with an attendant for the Dependent Children if necessary and if the Dependent Children are not accompanied by the Spouse; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person; and
2) for lodging and meals for up to 10 days for the Insured Person's Spouse and Dependent Children in the area where the Insured Person's death occurred, if they were accompanying the Insured Person at that time. We will only pay for such expenses for days in excess of the days that had been planned for the trip prior to the Insured Person's death, and only prior to the repatriation of his or her remains. We will not pay for such expenses in excess of, for the Spouse and Dependent Children combined, $100 per day for lodging and $50 per day for food.

IDENTIFICATION AND ESCORT EXPENSE BENEFIT

If an Insured Person suffers an Injury or an Emergency Sickness that results in loss of life and the Repatriation of Remains Benefit is payable, We will pay for expenses reasonably incurred if an Immediate Family Member or authorized representative incurs Identification Expenses or Escort Expenses while:

1) en route and during the stay in the city or town where the Insured Person's body is located, including transportation by the most direct route by a licensed Common Carrier to and from such location, but not to exceed the cost of one round-trip economy airfare ticket; and
2) for lodging and meals for up to 10 days for such person in the area where the Insured Person's death occurred, and not to exceed $100 per day for lodging and $50 per day for meals.

LIMITATIONS AND EXCLUSIONS

Our designated travel assistance provider must make all arrangements and must authorize all expenses in advance of any benefits being payable. Benefits will not be payable unless We authorize in writing, or by authorized electronic or telephonic means, all expenses in advance, and services are rendered by Us or Our designated travel assistance provider. We reserve the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Us in advance. In the event the Insured Person refuses to be evacuated, We will not be liable for any expenses incurred after the date medical evacuation is recommended.

Benefit B-51: Seat Belt and Airbag Benefit

SEAT BELT BENEFIT

If an Insured Person suffers a loss of life for which the Accidental Death Benefit is payable under the Policy and the Accident causing death occurs while the Insured Person is operating, or riding as a Passenger in, an Automobile and wearing a properly fastened Seat Belt, We will pay the Seat Belt Benefit.

The Seat Belt Benefit is equal to the lesser of:

1) the Percentage of Principal Sum shown in the Rider Schedule; or
2) the Maximum Benefit Amount shown in the Rider Schedule.

AIRBAG BENEFIT

If the Insured Person is wearing a Seat Belt and received a payment as indicated above, We will pay the Airbag Benefit if:

1) the Insured Person was positioned in a seat equipped with a factory installed Airbag;
2) the Insured Person was properly strapped in the Seat Belt when the Airbag inflated; and
3) the police report establishes that the Airbag inflated properly upon impact.

The Airbag Benefit is equal to the lesser of:

1) the Percentage of Principal Sum shown in the Rider Schedule; or
2) the Maximum Benefit Amount shown in the Rider Schedule.

LIMITED BENEFIT

If a police report is not available, or it is unclear whether the Insured Person was wearing a Seat Belt, or positioned in a seat protected by a properly functioning and properly deployed Airbag, We will pay a limited benefit of $1,000.

RIDER SCHEDULE

Seat Belt Benefit

	Percentage of Principal Sum	Maximum Benefit Amount
Classes 1, 2, 3, 4, 5 & 6	10% of Principal Sum	$50,000

Airbag Benefit

	Percentage of Principal Sum	Maximum Benefit Amount
Classes 1, 2, 3, 4, 5 & 6	10% of Principal Sum	$50,000

Benefit B-55: Therapeutic Counseling Benefit

We will pay the Percentage of Principal Sum up to the Maximum Benefit Amount shown in the Rider Schedule for expenses incurred by the Insured Person for Therapeutic Counseling sessions up to the Therapeutic Counseling Benefit Amount per session for the Maximum Number of Sessions as shown in the Rider Schedule below, if:

1) an Insured Person incurs a Covered Loss, other than a loss of life, for which a benefit is payable under the Accidental Dismemberment or Paralysis the Policy; and
2) the Insured Person initially requires Therapeutic Counseling within 365 days due to the Covered Loss.

Benefits for any Therapeutic Counseling session must be incurred within 2 year(s) after the date of the Covered Accident causing the Injury.

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, evidence of expenses incurred for services provided for Therapeutic Counseling is required in order to receive benefits under the Rider.

CLAIMS PROVISIONS

Notice of Claim
The person who has the right to claim benefits (the claimant, beneficiary or his or her representative) must give Us written Notice of a Claim within 30 days after a Covered Loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice should include the Insured Person's name and the Policy Number. Notice should be given to Our agent or sent to Us at The Hartford.

Claim Forms
When We receive the notice of claim, We will send forms to the claimant for giving Us Proof of Loss. The forms will be sent within 10 days after We receive the notice of claim. If the forms are not received, the claimant will satisfy the Proof of Loss requirement if a written notice of the occurrence, character and extent of the loss is sent to Us.

Proof of Loss
Written Proof of Loss must be furnished to Us within 180 days after the date of the loss. 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 We may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give 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.

All Proof of Loss submitted must be satisfactory to Us and must include information which is required by Us to adjudicate the claim. In addition, the claimant must provide Us any Proof of Loss documentation specifically required in any relevant Rider. We reserve the right to request additional information reasonably related to the claim.

Time of Payment of Claims
We will pay any benefit due, other than benefits for which the Policy provides periodic payment, immediately after We receive Proof of Loss. Subject to due written Proof of Loss, all accrued benefits for which the Policy provides periodic payment will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which benefits are due, and any balance remaining unpaid at the termination of the period will be paid immediately upon receipt of the proof.

Payment of Claims
We will pay any benefit due for loss of life:

1) according to the written beneficiary designation on file with the Policyholder; otherwise, if no beneficiary is named or no named beneficiary survives the Insured Person, We will pay
2) to the survivors in equal shares, in the first of the following classes to have a survivor at the Insured Person's death:
    a) Spouse;
    b) children;
    c) parents;
    d) brothers and sisters.

If there is no survivor in these classes or if there are legal impediments to determining who the survivors or beneficiaries are, payment will be made to the Insured Person's estate. All other benefits due and not assigned will be paid to the Insured Person, if living. Otherwise, the benefits will be paid according to the preceding language.

If a benefit due is payable to:

1) the Insured Person's estate; or
2) the Insured Person or a beneficiary who is either a minor or not competent to give a valid release for the payment,

We may pay up to $1,000 of the benefit due to some other person whom We believe is entitled to the payment, and who is related to the Insured Person or the beneficiary by blood or marriage. We will be relieved of further

responsibility to the extent of any payment made in good faith. We may pay benefits directly to any Hospital or person rendering covered services, unless the Insured Person requests otherwise in writing. The Insured Person must make the request no later than the time he or she files Proof of Loss.

Upon receipt of due written Proof of Loss, benefit payments for charges incurred by the Insured Person for covered medical services will be made directly to the provider at Our option. If any such charges have been paid by the Insured Person, the benefit payment for those charges will be made to the Insured Person upon written proof of payment.

Modified Payment of Claims

When We receive notice for losses suffered by an Insured Person whose residence is outside the United States, We may pay any benefits that may become payable under the Policy to the Policyholder, who:

1) will hold such payment in trust for the sole use and benefit of the Insured Person or his or her beneficiary or other person to whom such benefits are payable (the Payee), as described in the Payment of Claims provision within this section;
2) will transmit such payment to such Payee in accordance with the Payment of Claims and Time of Payment of Claims provisions of this section;
3) agrees that any such payment made by Us to the Policyholder constitutes a full discharge of Our liability with respect to the claim for which payment is made;
4) will alone assume full responsibility for the proper application or distribution of such payment; and
5) will indemnify, defend and hold Us harmless for any claims, demands, judgments, losses, costs, expenses, liabilities and damages whatsoever, including interest, penalties and legal fees, arising from or relating in any way to such payment or to the amount, application or distribution thereof; and
6) will, with respect to any application or disbursement of such payment in foreign currency, use the foreign exchange rate in effect at the Policyholder's payor bank on the date the benefits become payable to convert United States of America dollar-denominated currency into foreign currency.

Appealing Denial of Claims

If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the Insured Person. This written decision will:

1) give the specific reason or reasons for denial;
2) make specific reference to Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

On any denied claim, an Insured Person or his representative may appeal to Us for a full and fair review. The claimant may:

1) request a review upon written request within 60 days of receipt of claim denial;
2) review pertinent documents; and
3) submit issues and comments in writing.

We will make a decision no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons for the decision on which the decision is based.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to have:

1) a claimant for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and
2) an autopsy conducted for a claimant for whom a claim is made in case of death, where not prohibited by law.

Legal Actions
No legal action may start:

1) until 60 days after Proof of Loss has been given; or
2) more than 3 years after the time Proof of Loss is required to be given, unless otherwise required by law.

Assignment
This insurance may not be assigned. The Insured Person may not assign any of his or her rights, privileges or benefits under the Policy. Benefit payments may be assigned as allowed in the Payment of Claims provision.

Workers' Compensation Coverage
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits. If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due

to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and

2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Before the Insurance Company can issue

an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date. Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45-day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice

was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability Claims

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action

in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits. a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies. c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.