

BLANKET ACCIDENT POLICY/CERTIFICATE

Underwritten by:
AXIS INSURANCE COMPANY
(A Stock Company)
(Herein called the Company)

Administrative Office:
10000 Avalon Blvd., Suite 200
Alpharetta, GA 30009

Home Office:
233 South Wacker Drive, Suite 4930
Chicago, IL 60606

POLICYHOLDER: Volunteer Insurance Service Association, Inc. Work Release Volunteer Program

SUBSCRIBER As per the Participating Organization Master Application

POLICY EFFECTIVE DATE: July 1, 2025

POLICY NUMBER: SRPOAGI-ACR40000

POLICY TERM: July 1, 2025 through June 30, 2026

POLICY ANNIVERSARY DATE: July

1 STATE OF ISSUE: District of Columbia

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

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

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



Secretary



President

**LIMITED BENEFIT POLICY, PLEASE READ CAREFULLY
IT PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS
THIS POLICY MAY CONTAIN A DEDUCTIBLE
NON-PARTICIPATING**

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SCHEDULE OF BENEFITS

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

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

Subscriber & Subscriber Effective Date: As per the Participating Organization Master Application

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

Principal Sum

Class 1

All registered volunteers in a volunteer project or program sponsored by the Policyholder or a Participating Volunteer Organization whose names are on file with the Subscriber and for whom the appropriate premium has been paid. Coverage for participating organizations is effective as per the Effective Date and Expiration Date shown on the Participating Organization Application. No new registered volunteers will be accepted after the end of the Policy Term shown on the face page of the Policy.	\$2,500
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CONDITIONS OF COVERAGE

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

Class 1

POLICYHOLDER COVERAGE

Covered Activities:	Performance of duties necessary to carry out volunteer assignments made by the Policyholder or a Participating Volunteer Organization.
Personal Deviations Covered	Yes
Covered Travel	Includes Worldwide
Covered Overnight Travel	Includes Worldwide

BENEFITS

Aggregate Limit of Indemnity

Applies to:	Benefit Amount
Accidental Death and Dismemberment	\$250,000

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss must occur within	365 days of the Covered Accident
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Covered Loss	Benefit Amount
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Use of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Thumb and Index Finger of the same Hand	25% of the Principal Sum

ACCIDENT MEDICAL BENEFIT

Scope of Coverage Applicable to Accident Medical Benefits

Any benefit limits and benefit percentages apply, unless otherwise specified, on a per Insured Person – per Covered Loss basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable.

Full Excess Medical Expense	
Other Health Care Plan Reduction	50%
Total Maximum for all Accident Medical Benefits	Class 1 - \$25,000

First Covered Expenses must be incurred within	60 days after the Covered Accident
Benefit Period	52 weeks from the date of the Covered Accident
Deductible	Class 1 - \$200

Deductible applies to	each Covered Accident
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Covered Expenses	Benefit Percentage and Other Limits
Determination of the amount of each Covered Expense, and where applicable, each Usual and Customary Charge, will be made solely by the Company.	

Inpatient Hospital Services	
Room and Board Expenses	100% of Usual and Customary Charges
Intensive Care Unit	100% of Usual and Customary Charges
Private/Semi-Private Room	100% of Usual and Customary Charges

Miscellaneous Expenses (includes X-ray, CT Scan, MRI, Laboratory Tests, In-Hospital Physiotherapy, Orthopedic Appliances, Pre-Admission Tests)	100% of Usual and Customary Charges
Ambulatory Medical Center	100% of Usual and Customary Charges
Emergency Room Treatment	100% of Usual and Customary Charges
Physician Services	100% of Usual and Customary Charges
Surgery	100% of Usual and Customary Charges
*Allowance is calculated: 100% of Usual and Customary Charges for the 1 st procedure, 50% of Usual and Customary Charges for the 2 nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/portals.	
Assistant Surgeon	100% of Usual and Customary Charges
*Allowance is calculated: 25% of the surgeons allowed amount for the surgery performed to the surgical maximum.	
Anesthesia and its Administration	100% of Usual and Customary Charges
*Allowance is calculated: 25% of the surgeons allowed amount for the surgery performed to the surgical maximum.	
Use of Physician's Surgical Facilities	100% of Usual and Customary Charges
Physician Assistant	100% of Usual and Customary Charges
Second Opinion or Consultation	100% of Usual and Customary Charges
In-Hospital Visits	100% of Usual and Customary Charges
Office Visits	100% of Usual and Customary Charges
Outpatient X-ray, CT Scan, MRI and Laboratory Tests	100% of Usual and Customary Charges
Outpatient Physiotherapy (includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)	100% of Usual and Customary Charges
Outpatient Nursing Services	100% of Usual and Customary Charges
Ambulance Services (Air and Ground)	100% of Usual and Customary Charges
Medical Equipment Rental (Includes Orthopedic devices)	100% of Usual and Customary Charges
Medical Services and Supplies	100% of Usual and Customary Charges
Dental Services	up to \$500 per tooth; \$900 per Covered Loss
Prescription Drugs	100% of Usual and Customary Charges
Eyeglasses, Contact Lenses, Hearing Aids	100% of Usual and Customary Charges up to \$200
Artificial Limbs, Eyes and Larynx	100% of Usual and Customary Charges
Home Health Care	100% of Usual and Customary Charges
Minimum Hospital Stay	1 consecutive day
Home Health Care must begin within	10 consecutive days after the Minimum Hospital Stay
Maximum Number of Home Health Care Visits	30
Rehabilitation Care Facility	100% of Usual and Customary Charges
Extended Care Facility	100% of Usual and Customary Charges
Minimum Hospital Stay	3 consecutive days
Extended Care must begin within	7 consecutive days after the Minimum Hospital Stay

PREMIUM RATE TABLE

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

As per Participating Organization Master Application, due and payable for the Policy Term, which is also the premium rate guarantee period.

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

Mode of Premium Payment Annually

Premium Due Date	The Effective Date listed on the Participating Organization Master Application
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Initial Premium	As per the Participating Organization Master Application
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Contributions	The cost of coverage is paid by the Subscriber. Minimum and deposit premiums are fully earned and non-refundable.
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Annual Premium Amounts:

\$60.00 per Covered Person; Minimum Premium: \$100 per Participating Volunteer Organization

GENERAL DEFINITIONS

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

Accident or Accidental	means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.
Aircraft	means a vehicle which: 1. has a valid Airworthiness Certificate; and 2. is being flown by a pilot with a valid license to operate the Aircraft.
Airworthiness Certificate	means a "Standard" Airworthiness Certificate issued by the Federal Aviation Agency of the United States of America or its equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.
Calendar Year	means January 1 st through December 31 st of any year.
Common Carrier or Public Conveyance	means: 1. a Conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or 2. a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.
Conveyance	means a motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority.
Covered Accident	means an Accident that results in a Covered Loss during the Policy Term.
Covered Activity or Covered Activities	means any activity that is shown in the <i>Schedule of Benefits</i> and: 1. takes place under one of the Conditions of Coverage specified in the <i>Schedule of Benefits</i>; and 2. is sponsored, organized, scheduled or otherwise provided by the Subscriber.
Covered Expenses	means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.
Covered Injury	means Accidental bodily injury: (1) which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force; (2) which results directly and independently from all other causes from a Covered Accident; and (3) which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.
Covered Loss	means a loss which meets the requisites of one or more benefits, and results from a Covered Accident, Covered Injury or Covered Activity.
Eligible Person	means an individual as defined in the <i>Schedule of Benefits</i> .

Eligible Domestic Partner means a person who:

1. is characterized by mutual caring and the sharing of the Insured Person's permanent residence
2. has resided with the Insured Person continuously for at least six months and is expected to reside with the Insured Person indefinitely;
3. has registered under §32-702(a);
4. is at least 18 years old and competent to contract;
5. is the sole domestic partner of the other person; and
6. is not legally married to any other person;
7. is not a blood relative any closer than would prohibit legal marriage.

An employee may insure a Domestic Partner if all of the following conditions are met:

1. the Insured Person has not been married to any person within the past 12 months;
2. the Domestic Partner is the only person meeting this Policy's definition of Domestic Partner with respect to the Insured Person;
3. the Insured Person and the Domestic Partner furnish a notarized affidavit or signed statement reflecting these requirements, and an agreement to notify the Company the requirements cease to be met, on a form acceptable to the Company.

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

Hospital means an institution that meets all of the following:

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

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics; or
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Insured Person incurs an expense.

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

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse or Eligible Domestic Partner, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

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

Insured Person	means an Eligible Person, as defined in the <i>Schedule of Benefits</i> , for whom required premium has been paid when due and for whom coverage under this Policy remains in force.
Medically Necessary	means medical services that: (1) are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) are ordered by a Physician and performed under His care, supervision or order. The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Policy.
Nurse	means a licensed graduate Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) who is not: 1. the Insured Person; 2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse or Eligible Domestic Partner 3. a person living in the Insured Person's household; or 4. a person employed or retained by the Subscriber.
Outpatient	means an Insured Person who is a patient and is not hospitalized overnight but who visits a Hospital, clinic, or associated facility for diagnosis or treatment.
Physician	means a licensed health care provider practicing within the scope of his license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not: 1. the Insured Person; 2. a parent, sibling, Spouse or Eligible Domestic Partner or child of either the Insured Person or the Insured Person's Spouse or Eligible Domestic Partner; 3. a person living in the Insured Person's household; 4. a person employed or retained by the Subscriber; or 5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.
Policyholder	means the entity, named on this Policy's face page, to which the Company issues this Policy.
Policy Term	means the time period defined for the Subscriber shown on this Policy's face page.
Private Passenger Automobile	means a validly registered, four wheel private passenger car, including Subscriber -owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxi cab, bus or other Public Conveyance will not be considered a Private Passenger Automobile.
Scheduled Airlines or Aircraft	means any carrier holding a certificate, license or similar authorization for civilian scheduled air transport issued by the country of the Aircraft's registry, and which, in accordance with that authorization flies, maintains and publishes schedules and tariffs for regular passenger service between named cities at regular and specified times, but only if the Aircraft is then used for any regular or chartered flight operated by such carrier.

Spouse	means the Insured Person's lawful spouse. The term includes Spouses of same sex marriages recognized as valid in another jurisdiction.
Subscriber	means any participating organization that is affiliated with the Policyholder and subscribes to the insurance plan provided by this Policy.
Usual and Customary Charge	means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.
We, Us, Our	means AXIS Insurance Company.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligibility	A person is eligible for insurance under this Policy when He meets the definition of Eligible Person shown in the <i>Schedule of Benefits</i> . An Eligible Person may be insured under only one covered class, even though He may be eligible under more than one covered class.
Effective Date of Changes	Any increase or decrease in the amount of insurance for the Insured Person resulting from a change in benefits provided by this Policy or a change in the Insured Person's covered class will take effect on the date of such changes.
Subscriber Effective Date	Insurance becomes effective for each Subscriber in consideration of the Subscriber's application, Subscription Agreement and payment of the Premium when due. Insurance for the Subscriber becomes effective on the Effective Date of Subscriber Participation.
Policy Effective Date	The Company agrees to provide Accident insurance benefits described in this Policy in consideration of the Policyholder's application and payment of the Premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page.
Termination of Insurance	Insurance for the Insured Person will end on the earliest of: 1. the date the person is no longer in an Eligible Class; 2. the end of the period for which the last premium is made; or 3. the date this Policy ends; or 4. the date the Subscriber with which the Insured Person is affiliated ceases to be a Subscriber under this Policy. Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of: 1. the end of the Benefit Period; and 2. the date benefits equal to any applicable benefit limit or maximums, as shown in the <i>Schedule of Benefits</i>, have been paid.

COMMON EXCLUSIONS

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

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. travel in any Aircraft owned, leased operated or controlled by the Subscriber, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Subscriber if the Aircraft may be used as the Subscriber wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. voluntary ingestion of any poison, gas or fumes;
9. injuries compensable under Workers' Compensation law or any similar law;
10. the voluntary use of illegal drugs; the intentional taking of over the counter medication not in accordance with recommended dosage and warnings instructions; and intentional misuse of prescription drugs;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
13. aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless the Company receives a written medical release from the Insured Person's Physician;
14. a cardiovascular, event or stroke resulting, directly and independently of all other causes, from exertion, as verified by a Physician, while the Insured Person participates in a Covered Activity;
15. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
16. benefits will not be paid for services or treatment rendered by any person who is:
 - a. employed or retained by the Subscriber;
 - b. living in the Insured Person's household;
 - c. an Immediate Family Member, including Eligible Domestic Partner of either the Insured Person or the Insured Person's Spouse or Eligible Domestic Partner;
 - d. the Insured Person.

CLAIM PROVISIONS

Beneficiary

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

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

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

Claim Forms

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

Notice of Claim

Written notice of claim must be given to the Company or its designated authorized agent within 30 days after the occurrence or commencement of the Insured Person's Covered Loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company or its designated authorized agent, with information sufficient to identify the Insured Person, is deemed notice to the Company. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form.

Payment of Claims

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

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments due have been made, the amount still payable will be paid to His beneficiary as described in the Beneficiary Provision.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to a parent, guardian, or other person actually supporting Him. If the payee has no legal guardian for His property, a payment not exceeding \$1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

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

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

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

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

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

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

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

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

ADMINISTRATIVE PROVISIONS

Cancellation

The Company or the Subscriber may cancel this Policy after the first year or Policy Term or as of any Premium Due Date, by giving the other party 31 days advance written or authorized electronic notice. Any premium rate guarantee will not affect the Company's or the Subscriber's right to cancel this Policy.

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

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

Grace Period

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

Premiums

Premium rates are expressed in, and premiums are payable in, United States currency. The Company will provide notifications of premiums due or premium changes, to the most current address in Our files, to the Subscriber.

Premium Payment

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

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

Premium Rate Changes

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

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

1. the terms of this Policy change;
2. coverage is reinstated following failure to pay premium during the Grace Period; or
3. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this Policy.

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

Premium Audit

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

Reinstatement

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

GENERAL PROVISIONS

Addition of New Insured Persons	All Insured Persons added to the Classes of Eligible Persons in the <i>Schedule of Benefits</i> are eligible for insurance under this Policy.
Assignment	The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if the Company receives it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void. This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.
Certificates	Where required by law, the Company will provide a certificate of insurance for delivery to the Insured Person. Each certificate will set forth a statement as to the insurance coverage to which the Insured Person is entitled, and to whom the insurance benefits are payable, and a statement as to any family member, Spouse or Eligible Domestic Partner or dependent's coverage. If family members or dependents are included in the coverage, the insurer need only issue one certificate to each family unit.
Clerical Error	A person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, the Company will adjust the premium fairly.
Conformity with Statutes	Any provision in this Policy that is in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.
Entire Contract; Changes	The Policy, Master Application and any attached papers make up the entire contract between the Subscriber and the Company. In the absence of fraud, all statements made by the Subscriber or any Insured Person will be considered representations and not warranties. No written statement made by an Insured Person will be used in any contest unless a copy of the statement is furnished to the Insured Person or, in the event of the death or incapacity of the Insured Person, to His beneficiary or personal representative. No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.
Examination of the Policy	This Policy will be available for inspection at the Subscriber's office during regular business hours.
Incontestability	The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, misrepresentation or fraud. However, the Company may contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

Misstatement of Fact	If the Subscriber has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.
Noncompliance with Policy Requirements	Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.
Policy Changes	No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. The Company may agree with the Subscriber to modify a plan of benefits without the Insured Person's consent.
Records	The Subscriber or its authorized Administrator will maintain the records of the Insured Person's insurance under this Policy. The Company will be permitted to examine the Subscriber's records relating to the insurance under this Policy at any reasonable time. The Subscriber is acting as an agent of the Insured Person for transactions relating to this insurance. The actions of the Subscriber will not be considered the actions of the Company.
Reporting Requirements	The Policyholder or its authorized agent must report all of the following to the Company by the Premium Due Date: 1. the names of all persons insured on the Policy Effective Date; 2. the names of all persons who are insured after the Policy Effective Date; 3. the names of those persons whose insurance has terminated; and 4. additional information required by the Company. The Company may, at the Company's discretion, waive reporting of any information specified above.
Subscriber Participation Under This Policy	An organization may elect to participate under this Policy by submitting a signed Subscriber participation agreement to the Policyholder. No participation by an organization is in effect until approved by the Company
Workers' Compensation	This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

CONDITIONS OF COVERAGE

This Section describes the Conditions of Coverage under which benefits provided by this Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the Common Exclusions sections in order to understand all of the terms, conditions and limitations of coverage.

POLICYHOLDER COVERAGE

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs during one of the Covered Activities shown in the *Schedule of Benefits*.

The Covered Activity must take place:

1. under one of the Conditions of Coverage shown in the *Schedule of Benefits*; and
2. on the premises of the Policyholder or Subscriber during normal hours of operation or during another scheduled time.

This Coverage also includes travel worldwide only directly and without interruption:

1. between the Insured Person's home or another meeting place designated by the Policyholder or Subscriber and the site of the Covered Activity; and
2. by Common Carrier providing transportation to the site of the Covered Activity or by Private Passenger Automobile driven by an adult with a valid drivers' license.

Coverage also includes travel by any Common Carrier providing transportation to a Covered Activity worldwide, when the Insured Person's participation in or attendance at it requires Him to be away from His normal residence for a stay of one or more nights.

Definitions

For purposes of this Condition of Coverage:

Personal Deviation means

1. an activity that is not reasonably related to the Insured Person's Covered Activity;
2. not incidental to the purpose of the Covered Activity;
3. such travel or activities coincide with the Insured Person's Covered Activity; and
4. Personal Deviation is limited to any consecutive 1 hour period immediately prior to, during or following such Covered Activity.

Exclusions

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

DESCRIPTION OF BENEFITS

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Losses

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

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

Exposure and Disappearance

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

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

Definitions

For purposes of this Benefit:

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

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

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

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

Exclusions

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

ACCIDENT MEDICAL BENEFIT

Medically Necessary Covered Expenses and any applicable Deductibles are shown in the *Schedule of Benefits*. Medically Necessary Covered Expenses must be incurred within the Benefit Period shown in the *Schedule of Benefits*.

Other Health Care Plan Benefits

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

Full Excess Medical Expense

The Company will pay the Medically Necessary Covered Expenses:

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

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

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

1. the Insured Person has coverage under any Other Health Care Plan;
2. the Other Health Care Plan is an HMO, PPO or similar arrangement; and
3. the Insured Person does not use the facilities or services of the HMO, PPO or similar arrangement.

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

Covered Expenses

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

Benefits will be paid:

1. when Medically Necessary Covered Expenses incurred exceed any applicable Deductible within the number of days from the date of the Covered Accident specified in the *Schedule of Benefits*;
2. as long as the first expense has been incurred within the number of days specified in the *Schedule of Benefits*;
3. until any applicable Benefit Period shown in the *Schedule of Benefits* has expired;
4. until the total of Medically Necessary Covered Expenses paid equals any applicable Benefit Limit or Maximum Benefit shown in the *Schedule of Benefits*; and
5. until Benefits paid equal the Total Maximum for all Accident Medical Benefits shown in the *Schedule of Benefits*.

Inpatient Hospital Services	Room and Board Expenses The Company will pay for: 1. confinement in an intensive care unit for each day of such confinement; and 2. any other confinement, up to the maximum daily benefit shown in the <i>Schedule of Benefits</i> for each day of the Hospital Stay.
Miscellaneous Expenses	The Company will pay the Miscellaneous Expenses charged by a Hospital or ambulatory surgical center for Outpatient surgery. Miscellaneous Expenses include, but are not limited to: X-ray, laboratory, In-Hospital physiotherapy, orthopedic appliances, pre-admission tests and all necessary charges other than room and board, for services received during a Hospital Stay
Ambulatory Medical Center	The Company will pay Medically Necessary Covered Expenses incurred for medical or surgical treatment provided in a licensed facility providing ambulatory surgical or medical treatment that is not a Hospital or Physician's office.
Emergency Room Treatment	The Company will pay Medically Necessary Covered Expenses incurred for Outpatient emergency room treatment performed in a Hospital, up to the Maximum Benefit shown in the <i>Schedule of Benefits</i>. When emergency room treatment is immediately followed by admission to a Hospital, such treatment will be a Medically Necessary Hospital Covered Expense.
Physician Services	The Company will pay Medically Necessary Covered Expenses incurred for Physician Services listed below. Surgery – 1. Medically Necessary Covered Expenses charged for performing a surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure; 2. Medically Necessary Covered Expenses charged by an assistant surgeon assisting a Physician performing a surgical procedure; 3. Medically Necessary Covered Expenses charged for treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including aftercare, which is given in the Outpatient department of a Hospital or an ambulatory surgical center; and 4. any braces, splints or other devices required after surgery to ensure proper healing. Use of Physician's Surgical Facilities – Medically Necessary Covered Expenses charged for the use of the Physician's surgical facilities. Second Opinion or Consultation – Medically Necessary Covered Expenses charged by a Physician for a second surgical opinion, or consultation. Physician's Assistant – Medically Necessary Covered Expenses charged by a Physician's Assistant for other than pre or post-operative care, second opinion or consultation: 1. for In-Hospital visits; and 2. for office visits. Anesthesia and its Administration – Medically Necessary Covered Expenses charged by a Physician for anesthesia and its administration.

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

1. for In-Hospital visits; and
2. for office visits.

Outpatient X-ray, CT Scan, MRI and Laboratory Tests

The Company will pay Medically Necessary Covered Expenses incurred for X-rays, except dental X-rays, CT Scans, MRI's, and laboratory tests.

Outpatient Physiotherapy

The Company will pay Medically Necessary Covered Expenses incurred for Outpatient Physiotherapy. Physiotherapy means acupuncture, microthermy, manipulation, diathermy, massage therapy, heat treatment, and ultrasonic treatment.

Outpatient Nursing Services

The Company will pay Medically Necessary Covered Expenses incurred for Outpatient services rendered by a Nurse.

Ambulance Services

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

Medical Equipment Rental

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

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

Medical Services and Supplies

The Company will pay Medically Necessary Covered Expenses incurred for:

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

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

Dental Services

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

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

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

If there is more than one way to treat a dental problem, the Company will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

Prescription Drugs

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

Eyeglasses, Contact Lenses, Hearing Aids

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

Artificial Limbs, Eyes and Larynx

The Company will pay Covered Expenses incurred for initial artificial limbs, eyes and larynx, including fitting.

Home Health Care

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

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

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

Rehabilitation Facility

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

Extended Care Facility

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

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

Definitions

For purposes of this Benefit:

Deductible means the amount of Medically Necessary Covered Expenses that must be paid by the Insured Person before benefits will become payable under this Policy. A separate Deductible shall apply to each Covered Accident. The Deductible shall be reduced by the amount of medical expenses paid or payable under an Other Health Care Plan for medical expenses arising out of the Covered Injury that gave rise to the claim under this Policy.

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

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

Other Health Care Plan or Other Health Plan means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or

services for healthcare, dental care, disability benefits or repatriations of remains. Any Other Health Care Plan includes group, blanket, franchise, family or individual:

1. insurance policies;
2. subscriber contracts;
3. uninsured agreements or arrangements;
4. coverage provided through Health Maintenance Organizations, Preferred Providers Organizations and other prepayment, group practices and individual practice plans;
5. medical benefits provided under automobile "fault" and "no-fault" type contracts; and
6. medical benefits provided by any governmental plan or coverage or other benefit law, except:
 - a) a state sponsored Medicaid plan; or
 - b) a plan or law providing benefits only in excess of any private or nongovernmental plan.

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

EXCLUDED EXPENSES

The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
- 0.
3. treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
5. rest cures or custodial care;
6. repair or replacement of existing dentures, partial dentures, braces or bridgework;
7. expenses payable by any automobile insurance policy without regard to fault;
8. treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the Covered Activity;
9. except as state mandates, treatment of HIV/AIDS, meaning Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome or AIDS Related Complex (ARC) regardless of the means by which it was acquired;
10. treatment of Hernia of any kind. Hernia means a rupture or protrusion of an organ or part through connective tissues or through a wall of a cavity in which it is normally enclosed;
11. treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Accident, unless the Company has received a written medical release from his Physician; or
12. treatment of an injury resulting from or contributed to by frostbite, fainting or seizures, or heatstroke or heat exhaustion.

In no event will the Company's total payments for the Insured Person or exceed the Total Maximum for all Accident Medical Benefits shown in the *Schedule of Benefits*.

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

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS, AND CONSUMER PROTECTIONS

General Purposes

Residents of the District of Columbia should know that licensed insurers or health maintenance organizations who sell health benefit plans, disability income insurance, long-term care insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subject to certain statutory limits explained under the "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 et seq.), provides insolvency protection for certain types of insurance policies and contracts. The insolvency protections provided by the Guaranty Association are generally conditioned on a person being 1) a resident of the District of Columbia and 2) either the individual insured or an owner under a health benefit plan, disability income insurance, long-term care insurance, life insurance, or annuity contract issued by a member insurer or the individual insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also generally covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
 - \$300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
 - \$300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
 - \$300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
 - \$300,000 for long-term care insurance benefits;
 - \$300,000 for disability income insurance benefits;
 - \$500,000 for health benefit plans;
 - \$100,000 for coverage not defined as disability income insurance; health benefits plans; or long-term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than \$300,000 in benefits with respect to any one life (except in the event of health benefit plans in which the Guaranty Association is liable for no more than \$500,000).

Additionally, the Guaranty Association is not obligated to cover more than \$5,000,000 for multiple non-group policies of life insurance with one owner, regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia at the time the policy or contract was issued; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits, or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Consumer Protections

To learn more about the above referenced protections, please visit either:

**District of Columbia
Life and Health Insurance Guaranty
Association**
www.dclifeqa.org
410-248-0407

**District of Columbia
Department of Insurance, Securities and Banking**
disb.dc.gov
(202) 727-8000

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association will cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any right established in any policy or contract or under the Act.



HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AXIS Insurance Company values its relationship with you. Protecting the privacy of the information we have about you is of great importance to us. We want you to understand how we protect the confidentiality of information as well as how and why we use and disclose it. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to this information. "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare.

This privacy policy applies to policies underwritten by AXIS Insurance Company. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice. We reserve the right to change the terms of this notice, and should that occur, we will provide you with a copy of the new notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose your Protected Health Information (PHI) for the purposes of your treatment, for payment and for health care operations. Not every use or disclosure in a category is listed. However all of the ways that we may use or disclose PHI will fall within one of these categories.

Your Authorization: Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing use or disclosure. You may take away this authorization at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

For Payment: We use and disclose PHI as necessary for payment purposes. For example, we may use your PHI to process a claim or may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and disclose PHI for our health care operations such as customer service, premium rating, fraud and abuse prevention and detection, and other functions related to your health policy. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To Others: You may authorize us in writing to give your PHI to someone else for any reason. Also, if you are present, and provide authorization, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are unavailable, incapacitated, or facing an emergency medical situation, we may share limited PHI with a family member, friend or other person if sharing your PHI is in your best interest.



HIPAA PRIVACY NOTICE

As Allowed or Required by Law: We may also use or disclose your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared for any purpose as required by law.

We may share PHI with the sponsor of the plan or use in the administration of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

YOUR HIPAA PRIVACY RIGHTS

Access to Your PHI

You have the right to obtain a copy and inspect specific items of your PHI, such as your policy or claim information, for as long as we maintain it. We may deny your request to access certain PHI, as permitted or required by law. We may require your request for access in writing. Your request for access should contain as much detail as possible regarding the PHI you wish to review. We may charge a reasonable fee for access to your PHI.

Amendments to Your PHI

You have the right to request that the PHI we maintain about you be amended or corrected if you believe it is incorrect. We are not legally obligated to make all requested amendments but will give each request appropriate consideration. Requests for amendment must be in writing and must state the reasons for the amendment request.

Accounting for Disclosures of Your PHI

You have the right to request an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. Requests must be made in writing. We are not legally obligated to provide an accounting of every disclosure but will give each request appropriate consideration. The accounting will not include disclosures made prior to June 1, 2011.

Restrictions on Uses and Disclosures of Your PHI

You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. We are not legally required to agree to your restriction request but will give each request appropriate consideration.

Confidential Communication of PHI

You have the right to request to receive communications from us regarding your PHI by another method of contact or at an alternative address. We will accommodate reasonable requests, which must clearly state that disclosure of all or part of the information could endanger your health or safety.

Right to a Copy of the Notice

You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.



HIPAA PRIVACY NOTICE

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services in Washington, D.C. We will not take action against you for filing a complaint.

Contact Information

If you have questions or need further assistance regarding this Notice, or wish to exercise any of the abovementioned rights, you may write to us at

Administrative Address:

AXIS Insurance

10000 Avalon Blvd.

Suite 200

Alpharetta, GA 30009

888.870.AXIS (2947)

General questions - please send to DPO@axiscapital.com

Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective June 1, 2011

OFAC NOTICE

Payment of claims under any insurance policy issued shall only be made in full compliance with all United States economic or trade and sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").