

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET SCHOOL ACCIDENT INSURANCE POLICY

POLICYHOLDER: Palomar Community College District
POLICY NUMBER: US2150048
POLICY EFFECTIVE DATE: August 1, 2025
POLICY EXPIRATION DATE: July 31, 2026
PREMIUM DUE DATE: MONTHLY IN ADVANCE ON THE 1ST OF EACH MONTH

The Policy is delivered in and governed by laws of the state of California.

The Policy contains the terms under which the Company agrees to insure certain persons and pay benefits.

The Company and the Policyholder have agreed to all the terms of the Policy.

The Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in the Policy.

THIS IS ACCIDENT ONLY COVERAGE.

READ IT CAREFULLY

THE POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.

Signed for United States Fire Insurance Company By:



Marc J. Adey
Chairman and CEO



Michael P. McTigue
Secretary

RIGHT TO EXAMINE AND RETURN POLICY. This Policy can be returned for any reason within 10 days after it is received by the Policyholder. The Policy should be returned by mail or in person to the Company. Any premium paid will be refunded and the Policy will be treated as if it were never issued.

You may contact Us at: 5 Christopher Way, Eatontown, NJ 07724 Customer Service #: 1-973-490-6600 And/or Your Agent or Broker.

The California Department of Insurance should be contacted only after discussions with Us, or Our agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. Contact Your agent or broker for assistance.

You may contact the California Department of Insurance's Consumer Communications Bureau at: 300 South Spring Street, South Tower, Los Angeles, CA 90013.
Consumer Hotline: 1-800-927-HELP (4357) or 1-213-897-8921.
Website: insurance.ca.gov

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SCHEDULE OF BENEFITS

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though they may be eligible under more than one class. Also, a person may not be covered as a Dependent and an Insured Person at the same time.

Class	Description of Classes
1	All registered student athletes, student coaches, student managers and student trainers of the following sports: Football, Gymnastics, Skiing (snow), Soccer, Surfing and Wrestling, Police & Fire Academy.
2	All other registered students and student athletes of the policyholder.

HAZARDS INSURED AGAINST

The following are the **Hazards** for which insurance applies:

Class	Hazard	
1	Covered Activity Hazard	<p>Activities Start Date: 08/01/2025. Activities End Date: 07/31/2026</p> <p>Supervised or Sponsored Covered Activities Detail: Participation in scheduled, sponsored and approved intercollegiate sports activities of the Policyholder</p> <p>Travel to Covered Activities Location: Included</p>
2	Covered Activity Hazard	<p>Activities Start Date: 08/01/2025. Activities End Date: 07/31/2026</p> <p>Supervised or Sponsored Covered Activities Detail: Participation in Policyholder on-premises and off-premises scheduled, sponsored and approved activities. Off-premises activities will be included when traveling as a group.</p> <p>Travel to Covered Activities Location: Included Personal Time: Not-Included Sojourn or Personal Deviation: Not-Included</p>

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

All Classes	
	Maximum Benefit Amount per Covered Accident+
Accidental Death and Dismemberment	
Class 1	Up to \$25,000
Class 2	Up to \$50,000
Aggregate Limit:	\$500,000 Per Covered Accident

ACCIDENT MEDICAL EXPENSE BENEFIT

Any Benefit Periods, and Benefit Maximums apply on a per Covered Person per Accident basis.

All Classes	
Maximum Benefit Amount	Class 1 \$25,000 Class 2 \$50,000 per Covered Person per Covered Accident
Maximum Benefit Period	1 year from the date of the Covered Accident, provided the medical Expense occurs prior to the end of the Benefit Period and while the Policy is in force.
Scope of Coverage	Full Excess Benefits
Eligible Expenses	Maximum Amount Payable per Covered Accident
Hospital	
1) Maximum Hospital Confinement:	100% of Reasonable and Customary Charges for a semi-private room rate
2) Maximum ICU Hospital Confinement (paid in lieu of Hospital Confinement):	100% of Reasonable and Customary Charges for a semi-private room rate
Private Duty Nurse:	100% of Reasonable and Customary Charges
Emergency Room:	100% of Reasonable and Customary Charges
Prosthesis	100% of Reasonable and Customary Charges, up to \$1,000 per Covered Accident
Outpatient Surgical Center	100% of Reasonable and Customary Charges
Physician Each Visit	100% of Reasonable and Customary Charges
Anesthesia	100% of Reasonable and Customary Charges
Durable Medical Equipment Rental	100% of Reasonable and Customary Charges, up to \$2,000 per Covered Accident
Ambulance	100% of Reasonable and Customary Charges
Radiological Procedures	100% of Reasonable and Customary Charges
Outpatient Laboratory Tests	100% of Reasonable and Customary Charges
Prescription Drug	100% of Reasonable and Customary Charges
Rehabilitation Care Facility	100% of Reasonable and Customary Charges

Dental	100% of Reasonable and Customary Charges, up to \$2,000
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Skilled Nursing Facility	100% of Reasonable and Customary Charges, up to 100 days per Covered Accident
Home Health Care	100% of Reasonable and Customary Charges, up to 100 days per Covered Accident
Chiropractic Care:	100% of Reasonable and Customary Charges
Physical and Occupational Therapy	100% of Reasonable and Customary Charges, up to 24 Days, limited to one Treatment per Day

DEFINITIONS

For the purposes of the Policy the capitalized terms used herein are defined as follows:

Additional terms may be defined within the provisions to which they apply.

Accident means a sudden, unforeseeable external event which:

- 1) Causes Injury to one or more Covered Persons; and
- 2) Occurs while coverage is in effect for the Covered Person.

Aggregate means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

Benefit Period means the period of time from the date of the Accident causing the Injury for which benefits are payable, and the date after which no further benefits will be paid, as shown in the Schedule of Benefits.

Company means United States Fire Insurance Company, also referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include:

- False labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning sickness;
- Preeclampsia; and
- Similar conditions associated with the management of a difficult pregnancy, but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in

immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

Covered Activity means all activities that are supervised or sponsored by the Policyholder, including direct travel to and from such activities.

Covered Accident means an Accident that occurs during a Hazard for which coverage is in force for the Covered Person and which results in a Covered Loss.

Covered Loss or Covered Losses means an accidental death, dismemberment or other Injury for which benefits are indicated on the Schedule of Benefits.

Covered Person means an Insured Person and Dependent and Spouse or Domestic Partner and Child eligible for coverage as identified in the Schedule of Benefits, for whom proper premium payment has been made when due, and who is therefore insured under the Policy.

Effective Date means the date and time the Insured Person's coverage begins, as indicated in Effective Dates of Insurance section of the Policy, or if not specifically outlined therein, the date the Policyholder paid the total required premium for the coverage.

Eligible Expenses means the Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the treatment of the Injury. Eligible Expenses must be incurred while the Policy is in force.

Eligible Person means a person eligible for coverage as identified in the Class of Eligible Persons section of the Schedule of Benefits.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office. Emergency Room treatment includes all Hospital related services including Physician, x-ray and lab services shown in the Schedule of Benefits.

Experimental or Investigational means a service for which one or more of the following is true:

1. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. We will determine if this item 1. is true based on:
 - A. Published reports in authoritative medical literature; and
 - B. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the Food and Drug Administration (FDA).
2. In the case of a drug, a device or other supply that is subject to FDA approval:
 - A. It does not have FDA approval; or
 - B. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
 - 1) Included in substantially accepted peer-reviewed medical literature such as: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
 - 2) Included in a Prescription Drug reference compendium; or
 - 3) In addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
3. The Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to the board's approval.

4. Research protocols indicate that the service or supply is Experimental or Investigational. This item 4 applies for protocols used by the Covered Person's Provider as well as for protocols used by other Providers studying substantially the same service or supply.

Experimental Prosthesis means a prosthetic device based on untested ideas or techniques not yet established or finalized.

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.

Hazard(s) means the circumstances necessary for an event to be considered a Covered Loss under the Policy.

Hospital means an institution licensed, accredited or certified by the State that:

- 1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
- 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- 3) Provides 24-hour nursing service by Nurses on duty or call;
- 4) Has a staff of one or more licensed Physicians available at all times;
- 5) Provides organized facilities for diagnosis, treatment and surgery, either
 - a) on its premises; or
 - b) in facilities available to it, on a pre-arranged basis;
- 6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
- 7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Expense under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for Mental and Nervous Disorders or substance abuse, except as specifically stated.

Hospitalized or Hospital Confinement means a means an assignment to a bed as a resident inpatient in a Hospital or a licensed Skilled Nursing Facility on the advice of a Physician, or in an Observation Unit within a Hospital for a period of no less than 23 continuous hours on the advice of a Physician.

Immediate Family Member means the Covered Person's Spouse or Domestic Partner, parent, Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws.

Injury means bodily harm of which an Accident is the proximate cause. All injuries to the same Covered Person sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Insured Person means a person who is in a Class of Eligible Persons as defined under the Schedule of Benefits and for whom the required premium is made making insurance in effect for that person under the Policy. A Dependent covered under the Policy is not an Insured Person.

Medical Emergency means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

Mental and Nervous Disorders mean neurosis, psychoneurosis, psychopathic, psychosis; or mental or emotional disease or disorder of any kind. Mental and Nervous Disorders does not include drug addiction, marijuana addiction, or alcohol addiction.

Nurse means either a professional, licensed, graduate Registered Nurse (R.N.) or a professional, licensed practical Nurse (L.P.N.).

Occurrence means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

Physician means a person who is a qualified practitioner of medicine. As such, that person must be acting within the scope of their license under the laws in the state in which they practice and provide only those medical services which are within the scope of their license or certificate. It does not include the Covered Person or the Covered Person's Immediate Family or other relative.

Policyholder means the educational organization that elects to provide this coverage to their Classes of Eligible Persons shown in the Schedule of Benefits.

Prescription Drugs means drugs which may only be dispensed by written prescription under Federal law, and reapproved for general use by the Food and Drug Administration.

Principal Sum means the largest amount payable under the benefit for all losses resulting from any one Accident as shown on the Schedule of Benefits.

Prosthetic Device means a removable artificial substitute or replacement of a part of the body. A Prosthetic Device does not include:

- 1) dental aids, including false teeth or other artificial dental services;
- 2) eyeglasses;
- 3) cosmetic prosthesis such as hair wigs;
- 4) other types of prosthesis devices that are permanently implanted such as artificial hip or tooth; or
- 5) any Experimental Prosthesis; or
- 6) any auditory prosthesis.

Reasonable and Customary means:

- (1) With respect to fees or charges, fees for medical services or supplies which are:
 - (a) charged by the provider for the service or supply given; and

- (b) do not exceed the average charged for the service or supply in the Geographic Area in which the service or supply is received; or
- (2) With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

"Geographic Area" means the zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Sickness means illness or disease which requires treatment by a Physician while covered by the Policy. The Sickness must occur after the effective date of a Covered Person's coverage under the Policy and while the Policy is in force. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. Sickness includes Complications of Pregnancy.

Skilled Nursing Facility means an institution that fully meets one of the following tests:

1. It is approved by Medicare as a Skilled Nursing Facility.
2. If not approved by Medicare, the facility must be operated under the applicable licensing and other laws of the jurisdiction where it is located.

It cannot be, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, or a home for alcoholics or drug addicts or the mentally ill.

Sound Natural Teeth means natural teeth, the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

Spouse means lawful Spouse, if not legally separated or divorced, or Domestic Partner.

We, Us, and Our means United States Fire Insurance Company underwriting this insurance, or its authorized agent.

You, Your, Yours, He or She means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

Persons eligible to be insured under the Policy are: a person described as an Eligible Class on the Schedule of Benefits who is a U.S. citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, for whom proper premium payment has been made when due, and who is therefore insured under the Policy. This includes anyone who may become eligible while the Policy is in force.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

EFFECTIVE DATES OF INSURANCE:

Policy Effective Date. The Policy begins on the Policy Effective Date at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date:

The Covered Person will become an insured under the Policy, provided proper premium payment is made, on the latest of:

- (1) The Effective Date of the Policy; or
- (2) The day the Covered Person becomes eligible.

TERMINATION DATE OF INSURANCE:

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:

- 1) The Policy Expiration Date; or
- 2) The premium due date if premiums are not paid when due subject to any grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate the Policy on the last day of the grace period.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Insured Person's Termination Date. Coverage for the Insured Person will end on the earliest of:

- 1) The date the Insured Person is no longer in an Eligible Class; or
- 2) The date the Insured Person reports for full-time active duty in any Armed Forces, We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
 - a. The date the premium is fully earned; or
 - b. The Expiration Date of the Policy.This does not include Reserve or National Guard duty for training; or
- 3) The date the Policy is terminated.

PREMIUM PROVISIONS

PREMIUMS: The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the grace period.

The Company has the right to rely upon the accuracy of the Policyholder's calculations and to require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of premiums accruing after the first premium during which the Policy shall continue in force, but the Policyholder shall be liable to Us for the payment of the premium accruing for the period the Policy continues in force.

CHANGES IN PREMIUM RATE: The Company may change the premium rates from time to time with at least 60 days advanced written or authorized electronic notice. Notice will be sent to the Policyholder's most recent address in Our records.

No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12-month period. However, the Company reserves the right to change rates at any time if any of the following events occur:

- 1) A change in the terms of the Policy.
- 2) An Eligible Class is added or deleted to the Policy.
- 3) A change in any federal or state law or regulation affecting the Policy and Our benefit obligation.
- 4) A change in the factors bearing on the risk assumed.
- 5) A misrepresentation in the information relied on in establishing the rate for the Policy.
- 6) A change in the experience rating.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

HAZARDS INSURED AGAINST

Coverage will be provided for the Covered Person only when the Covered Person is engaged in at least one Hazard as described below and experiences a Covered Loss. Each Hazard is subject to the terms, conditions, limitations and exclusions contained in the Policy.

Note that the Hazard(s) may be different for each class of Eligible Persons. The Hazard(s) applicable to each Class of Eligible Persons is shown in the Schedule of Benefits.

Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if it is covered by more than one Hazard.

COVERED ACTIVITY HAZARD

This Hazard applies to the Covered Person when the Covered Person suffers an Injury as a result of a Covered Activity that occurs anywhere in the world while the Covered Person is covered under the Policy, and while on the premises of the Policyholder or while off the premises of the Policyholder.

The benefits under this Hazard do not apply to Accidents, Injuries or loss(es) sustained as a result of the Covered Person participating in a Covered Activity conducted in violation of the rules of the applicable governing body or the Policyholder. A Medical Release may be required by the Policyholder for participation in the Covered Activity.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If Injury from a Covered Accident, results in Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which the Covered Person is entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

<u>Loss</u>	<u>Benefit Amount (% of Principal Sum)</u>
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing (both ears)	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Accidental Death And Dismemberment

Definitions:

Except as defined below, the definitions in the Policy apply to 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 the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of speech means total, permanent and irrecoverable loss of audible communication.

Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

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

ACCIDENT MEDICAL EXPENSE BENEFIT

If a Covered Person suffers an Injury due to the Covered Accident that requires the Covered Person to be treated by a Physician, We will pay the Eligible Expenses incurred for Covered Medical Services that are received due to that Injury as shown in the Schedule of Benefits.

Benefits are subject to the terms of the Scope of Coverage section. Benefits are payable for Eligible Expenses incurred within the Maximum Benefit Period shown in the Schedule of Benefits.

Accident Medical Expense Covered Medical Services

Covered Medical Services under this benefit are as follows:

- 1) **Hospital:** the following services provided when the Covered Person is Hospitalized:
 - a) the daily room rate for a semi-private room when a Covered Person is Hospitalized 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 Hospitalized.
 - c) the daily room rate when a Covered Person is Hospitalized in a bed in the Intensive Care Unit (ICU) and nursing services other than private duty nursing services. If this benefit is paid, it will be in lieu of the Hospital Confinement benefit described in (a) above.

Treatment of Mental and Nervous Disorders is not covered as a Hospital service, even if treatment is provided in a Hospital.

- 2) **Private Duty Nurse:** private duty nursing services by a Nurse while a Covered Person is Hospitalized. These services must be ordered by a Physician.
- 3) **Emergency Room:** expenses incurred for treatment in an Emergency Room due to a Covered Accident. 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:** initial acquisition and fitting of Prosthetic Device. We will not pay for repair or replacement of any prosthesis;
- 5) **Outpatient Surgical Center:** treatment including operating room, laboratory tests, anesthesia, medical supplies, and medicines (excluding take home drugs) provided in an Outpatient Surgical 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 a Covered Person. Durable Medical Equipment (a) must be prescribed by a Physician who documents the necessity for the item

including the expected duration of its use; (b) can withstand long-term and repeated use without replacement; (c) is not useful in the absence of the covered Injury; (d) can be used in the home without medical supervision. The purpose of the equipment is not to help the Covered Person participate in sports activity. 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. Ambulance benefits shall be payable directly to the provider of the ambulance services unless We receive proof that such benefits have already been paid.
- 11) **Radiological Procedures:** Outpatient expenses for CAT Scan, MRI, x-ray, CT, PET, ultrasound, and other radiological procedures.
- 12) **Outpatient Laboratory Tests:** expenses for laboratory tests provided when the Covered Person is not Hospitalized and provided by a medical facility other than an Emergency Room or Outpatient Surgical Center.
- 13) **Prescription Drug:** expenses for drugs prescribed by a Physician and approved for general use by the Food and Drug Administration for the treatment of Injury and administered on an outpatient basis.
- 14) **Rehabilitation Care Facility:** inpatient 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 considered Sound Natural Teeth at the time of the Covered Accident.
- 16) **Mental and Nervous Disorders:** expenses for treatment of a Mental and Nervous Disorder that results directly from a Covered Accident while Hospitalized or on an Outpatient basis.
- 17) **Skilled Nursing Facility:** expenses for Confinement in a Skilled Nursing Facility if it begins within 5 consecutive days after a Covered Person is Hospitalized as a result of a Covered Accident. We will pay for treatment if a Physician visits the Covered Person at least once every 30 days and certifies that the Confinement is required.
- 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.

Accident Medical Expense Scope of Coverage

Full Excess Benefits: This benefit is secondary coverage to all other policies. We will pay Eligible Expenses incurred only after the Covered Person satisfies the Deductible and only when the Eligible Expenses are in excess of amounts paid or payable under any other benefit plan. We pay benefits without regard to any coordination of benefits provisions in any other benefit plan. The amount from other benefit plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits.

Accident Medical Expense Exclusions

Unless otherwise specified in this benefit, in addition to the general exclusions in the Policy, We will not pay Accident Medical Expense Benefits for any loss, treatment, or services resulting from:

- 1) complications of Pregnancy or miscarriage, except as a result of a Covered Accident;
- 2) elective or cosmetic surgery, except for Reconstructive Surgery needed as the result of an Injury;
- 3) orthopedic appliances used mainly to protect an Injury, so the Covered Person can participate in interscholastic, intercollegiate or club sports;
- 4) treatment or service provided by a private duty Nurse;
- 5) routine physical exams and medical services or wellness visits;
- 6) overuse symptoms including, but not limited to, bursitis, tendonitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, malfunctions of the heart, embolism, reinjures 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.);

- 7) Re-aggravation of a Prior Injury;
- 8) Injury for which expenses are incurred that are in excess of Reasonable and Customary Charges for Covered Medical Services, or expenses that are not covered;
- 9) Experimental or Investigative treatment or procedures.

These benefit(s) will not duplicate any other benefits payable under the Policy or any coverage(s) attached to the Policy.

HOME HEALTH CARE BENEFIT

If an Injury caused by a Covered Loss results in the Hospital Confinement of the Covered Person to a Hospital, Skilled Nursing Facility, Rehabilitation Care Facility, or Assisted Living Facility, and such loss requires continuing confinement of the Covered Person to their Primary Place of Residence beginning within 5 consecutive days after discharge from a Hospital, Skilled Nursing Facility, or Rehabilitation Care Facility, We will reimburse Home Health Care expenses as shown in the Schedule of Benefits. This is not a long-term care benefit.

In no event will benefits be payable beyond:

- 1) the Benefit Period as shown in the Schedule of Benefits; or
- 2) the date the Covered Person ceases to require Home Healthcare.

No Benefit Amount shall be paid if:

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

Home Health Care Definitions

Except as defined below, the definitions in the Policy apply to this benefit.

Home Health Care means nursing care, treatment and Daily Living Services provided in the Plan Participant's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

- 1) the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care; and Necessary care and treatment are not available from a Plan Participant's Immediate Family Member or other persons residing with the Plan Participant without causing undue hardship;
- 2) nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service; and
- 3) Daily Living Services must be provided by the attending Physician or by the provider of the nursing care service.

"Daily Living Services" are cooking, feeding, bathing, dressing and personal hygiene services that are necessary to a person's care and health.

Home Health Care consists of, but shall not be limited to, the following:

1. Part time and intermittent skilled nursing services: services given to the Plan Participant at least once every 60 days or as frequently as a few hours per day, several days per week.
2. Therapeutic services: physical therapy occupational therapy; speech and hearing therapy; and
3. Medical social services, medical supplies, drugs and medicines, related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Evidence of Coverage if the Plan Participant had remained in the Hospital.

These benefit(s) will not duplicate any other benefits payable under the Policy or any coverage(s) attached to the Policy.

PHYSICAL THERAPY BENEFIT

If the Covered Person suffers an Injury due to a Covered Accident, We will reimburse the Covered Person for Physical Therapy Expenses that result from the Injury up to the amount and number of days shown in the Schedule of Benefits for all Injuries caused by the same Accident.

Physical Therapy Definitions

Except as defined below, the definitions in the Policy apply to this benefit.

Physical Therapy Expense(s) includes charges for treatment and office visits connect with such treatment including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of Physical Therapy. Expenses

- 1) are charged for a service offered to the Covered Person, performed under the care, supervision or order of a Physician;
- 2) do not exceed the usual level of charges for similar treatment, supplies, or services in the locality where the expenses are incurred; and
- 3) do not include charges that would not have been made if no insurance existed.

These benefit(s) will not duplicate any other benefits payable under the Policy or any coverage(s) attached to the Policy.

PROSTHESIS BENEFIT

If the Covered Person suffers an Injury during a Covered Accident for which the covered Injury is payable under the Policy, We will pay an additional Benefit Amount shown in the Schedule of Benefits once Proof of Loss is received if:

- 1) such Injury requires use of a Prosthetic Device; and
- 2) the Prosthetic Device is required within the Maximum Benefit Period as shown in the Schedule of benefits of the Accident that caused the Injury.

Prosthesis Definitions

Except as defined below, the definitions in the Policy apply to this benefit.

Experimental Prosthesis means a prosthetic device based on untested ideas or techniques not yet established or finalized.

Prosthetic Device means a removable artificial substitute or replacement of a part of the body. A Prosthetic Device does not include:

- 1) dental aids, including false teeth or other artificial dental services;
- 2) eyeglasses;
- 3) cosmetic prosthesis such as hair wigs;
- 4) other types of prosthesis devices that are permanently implanted such as artificial hip or tooth; or
- 5) any auditory prosthesis.

These benefit(s) will not duplicate any other benefits payable under the Policy or any coverage(s) attached to the Policy.

POLICY LIMITATIONS

ECONOMIC OR TRADE SANCTIONS: Any payments under the Policy will only be made in full compliance with all United States of America economic or trade 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"). Therefore, any expenses incurred or claims made involving travel that is in

violation of such sanctions, laws and regulations will not be covered under the Policy. For more information, the Insured Person may consult the OFAC internet website at www.treas.gov/offices/enforcement/ofac/.

Limitation on Multiple Benefits: If the Covered Person suffers one or more Covered Losses from the same Covered Accident for which amounts are payable under one or more of the following 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:

Accidental Death & Dismemberment Benefit

Aggregate Limit:

The maximum amount the Company will pay for all Covered Losses resulting from the same Covered Accident will not exceed the Aggregate Limit of Insurance as described above. If a Covered Accident results in Benefit Amounts becoming payable, which when totaled, exceed the applicable Aggregate Limit of Insurance shown above, then the Aggregate Limit of Insurance will be divided proportionally among the Insured Persons, based on each applicable Benefit Amount.

EXCLUSIONS

The Policy does not cover any loss resulting from any of the following, unless otherwise covered under the Policy by Additional Benefits:

Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury.

1. War or any act of war, declared or undeclared.
2. An Accident which occurs while the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
3. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
4. Active participation in a riot or insurrection;
5. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling, assault or battery instigated by the Covered Person.
6. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an Accidental external bodily Injury or accidental food poisoning.
7. Any loss sustained or contracted in consequence of the Covered Person whose Injury is the basis of claim being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.
8. Any loss to which the proximate or substantial cause was the commission of or attempt to commit a felony by the Covered Person whose Injury is the basis of claim, or to which the proximate or substantial cause was such Covered Person's being engaged in an illegal occupation.
9. Eligible Expenses for which the Covered Person would not be responsible in the absence of the Policy.
10. Any treatment, service or supply not specifically covered by the Policy.
11. Loss resulting from participation in any activity not specifically covered by the Policy.
12. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
13. Regular health checkups;
14. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family Member of the Covered Person.
15. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
16. That part of medical expense payable by any Automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
17. treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay
18. Travel or activity outside the United States.
19. Participation in any motorized race or speed contest.
20. Aggravation or re-injury of a prior Injury that the Covered Person suffered prior to their coverage Effective Date, unless We receive a written Medical Release from the Covered Person's Physician.
21. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in the Policy.
22. Expense incurred for treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofascial pain, except as specifically provided in the Policy.
23. Dental care or treatment other than care of Sound Natural Teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under the Policy, and rendered within 6 months of the Accident;
24. Treatment for blood or blood plasma, except for charges by a Hospital for the processing or administration of blood;
25. Eyeglasses, contact lens, hearing aids braces, appliances, or examinations or prescriptions therefore;
26. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
27. Travel in or upon:
 - a. A snowmobile;
 - b. A water jet ski;

- c. Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
 - d. Any off-road motorized vehicle not requiring licensing as a motor vehicle; when used for recreation or competition.
28. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
- i. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - ii. While being used for any test or experimental purpose; or
 - iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
 - iv. While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder or by the Covered Person or any member of the Covered Person's household.
 - v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
- b. Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private Aircraft used for business or pleasure purposes.
29. Treatment for an Injury that is caused by or results from a nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
- (i) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and
 - (ii) The Covered Person was within a 25-mile radius of the site of the release either:
 - 1) At the time of the release; or
 - 2) Within 24 hours of the start of the release; or
30. Occurs while the Covered Person is in California.
31. For Class 2: Practice or play in any amateur, club sport, intercollegiate, interscholastic, intramural school activity or professional sports contest or competition.
32. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
33. Elective or Cosmetic surgery, except for Reconstructive Surgery on a diseased or injured part of the body;
34. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Us at 5 Christopher Way, Eatontown, NJ 07724 or Our Administrator or to any authorized agent of Ours, with sufficient information sufficient to identify the Covered Person, shall be deemed notice to Us..

CLAIM FORMS: We, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to Us, in the case of a claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which We are liable, and in the case of a claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce 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 Insured Person, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Indemnities payable under the Policy for any loss other than a loss for which the Policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the Policy provides periodic payment will be paid no less frequently than monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the Covered Person's death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

If any indemnity of the Policy shall be payable to the estate of the Covered Person, or to a Covered Person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

All benefits will be paid in United States currency.

PHYSICAL EXAMINATION AND AUTOPSY: We, at our own expense, shall have the right and opportunity to examine the person of any individual whose Injury is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder, and to make an autopsy in case of death, where it is not forbidden by law.

CHANGE OF BENEFICIARY: The right to change of beneficiary is reserved to the Covered Person, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary. A beneficiary may be changed by filling out a new beneficiary form. The Covered Person can get this form from the Administrator. The form must be received and recorded by the Administrator before the change of beneficiary becomes effective.

ASSIGNMENT: This coverage may not be assigned. However, benefit payments may be assigned at the time of claim. Any payment made by Us in good faith will end Our liability to the extent of the payment.

FACILITY OF PAYMENT: Whenever payments that should have been made under the Policy are made by any other policy, We shall have the right, exercisable at Our sole option, to pay over to any policy making such other payments any amounts We shall determine are warranted in order to satisfy the intent of this provision. The amounts so paid shall be considered benefits paid under the Policy and, to the extent of such payments, We shall be fully discharged from liability under the Policy.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: The Policy and the application of the Policyholder, if any, constitute the entire contract between the parties, and any statement made by the Policyholder or by any Covered Person shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under the Policy or be used in defense to a claim hereunder unless it is contained in a written application. No change in the Policy shall be valid unless approved by an executive officer

of the Company and unless such approval be endorsed herein or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After this Policy has been in force for a period of three years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Covered Person eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made.

No claim for loss incurred or disability (as defined in the Policy) commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

MISSTATEMENT OF AGE: If the age of any individual covered under the Policy has been misstated, the amount payable shall be such as the premium paid for the coverage of such individual would have purchased at the correct age.

CANCELLATION: The Company may cancel the Policy at any time by written notice delivered to the Policyholder, or mailed to his last address as shown on the records of the Company, stating when, not less than 31 days thereafter, such cancellation shall be effective; and after the Policy has been continued beyond its original term the Policyholder may cancel the Policy at any time by written notice delivered or mailed to the Company, effective on receipt or on such later date as may be specified in the notice. In the event of such cancellation by either the Company or the Policyholder, the Company shall promptly return on a prorata basis the unearned premium paid, if any, and the Policyholder shall promptly pay on prorata basis the earned premium which has not been paid. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

CONFORMITY WITH STATE STATUTES: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statutes.

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

RECORDS; RIGHT TO AUDIT:

Sufficient records must be maintained by the Policyholder to show the Covered Persons, the dates they became Covered Persons, amounts of benefits for each, the effective date of any change in the amount of insurance, the beneficiaries and other such information as may be required to administer the Policy.

We have the right to examine and audit these records at any reasonable time the Policy is in effect, within three years after the Policy is terminated, or later, if claims are still pending.

REPORTING REQUIREMENTS: The Policyholder or its authorized agent must report to Us, by the premium due date:

1. The names of all persons insured on the Effective Date of the Policy;
2. The names of all persons who are insured after the Effective Date of the Policy;
3. The names of those persons whose insurance has terminated; and
4. Additional information required as agreed to by us and the Policyholder.

CLERICAL ERROR: A clerical error may be made by the Company or the Policyholder in keeping the data. If so, when the error is found, the premium and/or benefits will be adjusted according to the correct data. An error will not end insurance validly in force, nor will it continue insurance validly ended.

DATA NEEDED: The Policyholder will keep a record of all the data needed to compute premiums and carry out the terms of the Policy. The Company can examine such data at any reasonable time.

NON-PARTICIPATING: The Policy is non-participating and the Policyholder does not share in any revenue or dividends.

NONCOMPLIANCE WITH POLICY REQUIREMENTS: Any express waiver by the Company of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

CERTIFICATES: Where it is required by law, or upon the request of the Policyholder, We will make available Certificates outlining the insurance coverage and to whom benefits are payable under the Policy.

NEW ENTRANTS: To the group originally insured may be added from time to time eligible new persons, in accordance with the terms of the Policy.