BLANKET ACCIDENT POLICY

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

Administrative Office:
1 University Square Drive, Suite 200
Princeton, NJ 08540

Home Office:
111 South Wacker Drive, Suite 3500
Chicago, IL 60606

POLICYHOLDER: The Firemen's Association of the State of New York

POLICY EFFECTIVE DATE: April 1, 2024

POLICY NUMBER: EXST-99674-NY10235

POLICY TERM: 04/01/2024 - 03/31/2025

POLICY ANNIVERSARY DATE: April 1

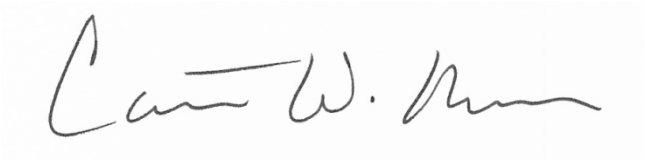
STATE OF ISSUE: New York

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

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 A.M. on the Policy Effective Date 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 terminates at 12:00 A.M., on the day following the last day of the Policy Term unless the Policyholder and the Company agree to continue coverage under this Policy for an additional Policy Term. The laws of the State of Issue shown above govern this Policy.

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

Secretary



President

THIS IS A LIMITED POLICY
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
PLEASE READ YOUR POLICY CAREFULLY
NON-PARTICIPATING

NOTICE – THIS POLICY DOES NOT MEET THE REQUIREMENTS OF A CONTINUING CARE RETIREMENT CONTRACT. AVAILABILITY OF THIS COVERAGE WILL NOT QUALIFY A RESIDENTIAL FACILITY AS A CONTINUING CARE RETIREMENT COMMUNITY

Table of Contents

SCHEDULE OF BENEFITS

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

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

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

Class A	**Principal Sum**
All Active Members of the Policyholder	$10,000

Class B	
All Active Members of the Policyholder	$20,000

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

Class A

24-HOUR BUSINESS AND PLEASURE HAZARD

Class B

LINE OF DUTY OCCUPATIONAL HAZARD

BENEFITS

Aggregate Limit of Indemnity

Applies to:	**Benefit Amount**
All Hazards	Ten times the Class A Principal Sum, not to exceed $1,000,000.

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses, Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident. that occurs under one of the Hazards, as specified above. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Loss must occur within	365 days of the Covered Accident

COMA BENEFIT

Must occur within and continue for	30 consecutive days of the Covered Accident

PARALYSIS BENEFIT

Must occur within	365 days of the Covered Accident

Covered Loss	**Benefit Amount**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Use of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of Speech and Hearing (in Both Ears)	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Use of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in Both Ears)	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all Toes of the Same Foot	25% of the Principal Sum
Loss of Thumb	25% of the Principal Sum
Coma	Up to 100% of the Principal Sum
Paralysis	
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum

Exposure and Disappearance Benefit	**Included**

BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

Counseling must occur within	30 days of the Loss of Life or Covered Loss.
Benefit Amount	$100 per session
Maximum Number of Sessions	10
Maximum Benefit per Covered Loss	$1,000

HOME ALTERATION AND VEHICLE MODIFICATION EXPENSE BENEFIT

Benefit Amount	10% multiplied by the portion of the Benefit Amount applicable to a Covered Loss for Accidental Death and Dismemberment, Coma, Paralysis, as shown in the Schedule of Benefits subject to a maximum of $10,000.

MEDICAL EVACUATION BENEFIT

Benefit Amount	100% of Usual & Customary Charges
Includes Traveling Companion	

PROSTHESIS APPLIANCE BENEFIT

Covered Loss must occur within	365 days of the Covered Accident
Benefit Amount	$1,000 per Covered Loss

REHABILITATION BENEFIT

Covered Treatment must occur within	365 days of the Covered Accident
Benefit Amount	10% multiplied by the portion of the Benefit Amount applicable to a Covered Loss for Accidental Death and Dismemberment, Coma, Paralysis, as shown in the Schedule of Benefits subject to a maximum of $10,000.

REPATRIATION BENEFIT

Benefit Amount	100% of Usual & Customary Expenses

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit Amount	5% multiplied by the Principal Sum applicable to the Covered Loss subject to a maximum of $50,000
Airbag Benefit Amount	5% multiplied by the Principal Sum applicable to the Covered Loss subject to a maximum of $25,000

PREMIUM RATE TABLE

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

Rate is $3.00 per insured member per year. Premium is based on 34,500 members.
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	Premium payments of $25,875 per quarter
Initial Premium	$103,500
Premium Due Date	Quarterly payments due on the following dates: 04/01/2024, 07/01/2024, 10/01/2024 and 01/01/2025.

GENERAL DEFINITIONS

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

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

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

Airworthiness Certificate means a “Standard" Airworthiness Certificate issued by the Federal Aviation Agency of the United States of America or its equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.

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

Common Carrier or Public Conveyance means:
1. a Conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.

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

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

Covered Activity or Covered Activities means any activity that is shown in the *Schedule of Benefits* and takes place under one of the Hazards specified in the *Schedule of Benefits*. and is sponsored, organized, scheduled by the Policyholde and is a covered Hazard.

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, results from a Covered Accident, Injury or Covered Activity, and for which benefits are payable under the Policy.

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

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

Hospital means an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.);
5. if located in New York State, has in effect a hopitilization review plan applicable to all patients which meets at least the standards set forth in section 1861 (k) of the United States Public Law 89-87, (42 USCA 1395x;
6. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and
7. it charges for its services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scheduled Airlines or Aircraft means any carrier holding a certificate, license or similar authorization for civilian scheduled air transport issued by the country of the Aircraft's registry, and which, in accordance with that authorization flies, maintains and publishes schedules and tariffs for regular passenger service between named cities at regular and specified times, but only if the Aircraft is then used for any regular or chartered flight operated by such carrier.

Spouse means the Insured Person's lawful spouse, regardless of sex. The term includes Spouses of same sex marriages recognized as valid in another jurisdiction.

Traveling Companion means an individual or individuals who have made advance arrangement with the Insured Person to travel together.

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

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligibility

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

Policy Effective Date

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

Effective Date of Changes

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

Termination of Insurance

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

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

Upon termination of insurance, if an Insured Person is Totally Disabled, an extension of benefits of 31 days from the date of termination shall be provided during a Hospital Stay, so long as the Insured Person remains Totally Disabled.

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

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

COMMON EXCLUSIONS

In addition to any benefit or hazard 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 Hazards Section:

1. suicide, attempted suicide or intentionally self-inflicted injury;
2. participation in a felony;
3. participation in a riot or insurrection;
4. declared or undeclared war or act of war;
5. aviation, other than a fare paying passenger on a scheduled or charter flight operated by a scheduled airline;

In addition, benefits will not be paid for services or treatment rendered by any person who is a member of the Insured Person's immediate family;

CLAIM PROVISIONS

Beneficiary

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

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

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

Claim Forms

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

Notice of Claim

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

Payment of Claims

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

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

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

who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

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

Time of Payment of Claims

Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid no more than 60 days after receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Conditional Claim Payment

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

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

Legal Actions

No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought after expiry of 2 years 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.

External Appeal

If a claim has been denied under this Policy on a basis a treatment or service was not Medically Necessary, the Insured Person or his authorized representative may appeal the decision to an External Appeal Agent, which is an Independent Review Entity certified by the State of New York to conduct such an appeal.

In order to make an external appeal, the claim denied on the basis that treatment or sevice was not Medically Necessary must otherwise by a Covered Loss.

The Insured Person has 45 days from receipt of a final notice of a claim denial to file a written request for an external appeal. The Company will provide an external appeal application to the Insured Person with the final claim denial.

The Insured Person may also request an external appeal application from the New York State Insurance Department at 1-800-400-8882. The completed application should be submitted to the Insurance Department at the address indicated in the application. If the Insured Person satisfies the criteria for an external appeal, the state will forward the request to an Independent Review Entity.

The Insured Person may submit additional documentation with the request. If the Independent Review Entity determines the information submitted represents a material change to the information on which the Company based its denial, the Independent Review Entity will provide this information to the Company, which has a right to reconsider its decision. If the Company chooses to exercise this right, the Company has three business days to amend or confirm its decision. The Company does not have the right to reconsider its decision in the case of an expedited appeal, which is explained below.

The Independent Review Entity must make a decision within 30 days of receipt of the Insured Person’s completed application. The Independent Review Entity may request additional information from the Insured Person, their doctor or the Company. If the Independent Review Entity requests additional information, it has five additional business days to make its decision. The Independent Review Entity must nofify the Insured Person in writing of its decision within two business days.

If the Insured Person's attending doctor certifies that the delay in providing any service or treatment that has been denied may pose an imminent or serious threat to the Insured Person's health, the Insured Person may request an Expedited External Appeal. In that case, the Independent Review Entity must make a decision within three days or receipt of the Insured Person's completed application. Immediately after reaching a decision, the Independent Review Entity must try to notify the Insured Person and the Company by telephone or facsimile of that decision. The Independent Review Entity must also notify the Insured Person in writing of its decision.

If the Independent Review Entity overturns the Company's decision that a treatment or service was not Medically Necessary, the Company will provide coverage subject to the other terms and conditions of the Policy.

The Independent Review Entity's decision is binding on both the Company and the Insured Person. The Independent Review Entity's decision is admissible in any court proceeding.

The Company will charge the Insured Person a fee of any amount up to $50 for an External Review. The External Review application will instruct the Insured Person on the manner in wich the fee must be submitted. The Company may also waive the fee if it determines the fee would pose a hardship on the Insured Person. If the Independent Review Entity overturns the denial of coverage, the fee shall be refunded to the Insured Person.

ADMINISTRATIVE PROVISIONS

Cancellation

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

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

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

Grace Period

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

Premiums

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

Premium Payment

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

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

Premium Rate Changes

The Company may change premium rates at the end of any Policy Term or any premium rate guarantee period with at least 45 days advance notice to the last known address of the Policyholder. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

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

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

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from

the date of the change to the end of any period for which premium has been paid.

Premium Audit

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

Reinstatement

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

GENERAL PROVISIONS

Addition of New Insured Persons

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

Assignment

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

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

Clerical Error

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

Conformity with Statutes

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

Entire Contract; Changes

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

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

Examination of the Policy

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

Incontestability

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

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

Misstatement of Fact

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

Noncompliance with Policy Requirements

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

Policy Changes

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

Records

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

Reporting Requirements

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

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

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

Workers' Compensation

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

HAZARDS

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

24-HOUR BUSINESS AND PLEASURE HAZARD

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

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

LINE OF DUTY OCCUPATIONAL HAZARD

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss that occurs during a Covered Activity and while the Insured Person is Acting in the Line of Duty.

The Covered Loss must take place while:
1. the Insured Person is on duty, on or off the Policyholder's premises; or
2. Acting in the Line of Duty during response to an emergency while off duty.

Definitions For purposes of this Hazard:

Acting in the Line of Duty means acts done according to the standards set by Policyholder for the type of work in which the Insured Person is engaged.

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

DESCRIPTION OF BENEFITS

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Losses

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

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

Exposure and Disappearance

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

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

Definitions

For purposes of this Benefit:

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

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

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

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

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

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

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

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

COMA BENEFIT

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

Definitions

For purposes of this Benefit:

Coma means a profound state of unconsciousness from which the Insured Person is not likely to be aroused through powerful stimulation. The state of unconsciousness results in loss of use of all appendages, plus sight and speech and an inability to perform Activities of Daily Living. The Coma must begin within 90 days of the Covered Accident, continue for 30 consecutive days and must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results form the administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Loss.

Exclusions

Exclusions that apply to the Benefit are in the Common Exclusions section.

PARALYSIS BENEFIT

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

Definitions

For the purposes of this Benefit:

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

Exclusions

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

BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits* for counseling sessions, subject to all applicable conditions and exclusions, when the Insured Person requires bereavement and trauma counseling because of an Accidental Death or Covered Loss under this Policy. Such counseling must meet all of the following conditions:

1. covered bereavement and trauma counseling expenses must be incurred within the time period shown on the *Schedule of Benefits* from the date of the Covered Accident causing another Insured Person's death;
2. the expense is charged for a bereavement or trauma counseling session for the Insured Person;
3. counseling is provided under the care, supervision or order of a Physician; and
4. a charge would have been made if no insurance existed.

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

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a Covered Loss and when all of the following conditions are met:

1. before the date of the Covered Accident, the Insured Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. as a direct result of such Covered Accident, the Insured Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle; and
3. the Insured Person requires home alteration or vehicle modification within one year of the date of the Covered Loss.

In order to be eligible for the Home Alteration or Vehicle Modification Benefit:

1. a Physician must certify that the home alteration or vehicle modification is necessary as a result of a Covered Loss;
2. the home alteration or vehicle modification must be made by someone experienced in such alterations and modifications;
3. the modification must be in compliance with the applicable laws or requirements of the appropriate governmental authority; and
4. the expense of the home alteration or vehicle modification must not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred.

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

MEDICAL EVACUATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person or Traveling Companion suffers a Covered Loss that warrants his or her Emergency Evacuation while He is outside a 100 mile radius from His current place of primary residence. The Company will pay for Covered Emergency Evacuation Expenses reasonably incurred for all Emergency Evacuations due to all Covered Losses from the same Accident or from the same related causes.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured Person's or Traveling Companion's Covered Losswarrants his or her Emergency Evacuation. All transportation arrangements made for the Emergency Evacuation must be by the most direct and economical Conveyance

and route possible. **AXIS's travel assistance service provider** must make all arrangements and must authorize all expenses in advance for this Benefit to be payable. However, the Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact **AXIS's travel assistance service provider** in advance.

Definitions

For purposes of this Benefit:

Covered Emergency Evacuation Expense(s) means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed; or (4) 100% of the Usual and Customary Charges.

Emergency Evacuation means, if warranted by the severity of the Insured Person's or Traveling Companion's Covered Loss: (1) the Insured Person's or Traveling Companion's immediate transportation from the place where he or she suffers a Covered Loss to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Insured Person's or Traveling Companion's transportation to His current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering a Covered Loss and being treated at a local Hospital or other medical facility; or (3) both (1) and (2) above. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such transportation.

Exclusions

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

PROSTHESIS APPLIANCE BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person suffers a Covered Loss that requires use of a Prosthetic Appliance Device. The Company will pay the Prosthesis Appliance Benefit when a charge is incurred. This Benefit is not payable for hearing aids, wigs, or any dental aids, including false teeth.

Definitions

For purposes of this Benefit:

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

- dental aids, including false teeth, treatment or repair of caps, crowns, braces, bridges, dentures, fillings or other artificial dental devices;
- eyeglasses;
- cosmetic prosthesis such as hair wigs;
- other types of prosthesis devices that are permanently implanted such as artificial hip or tooth;
- any experimental prosthesis; or
  any auditory prosthesis (a device that substitutes for or enhances ability to hear).

Exclusions

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

REHABILITATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, when the Insured Person

requires Rehabilitation after sustaining a Covered Loss. The Insured Person must require Rehabilitation within 365 days of the Covered Loss.

Definitions

For purposes of this Benefit:

Rehabilitation means medical services, supplies, treatment, Hospital Confinement or part of a Hospital Confinement that satisfies all of the following conditions:

1. is essential for physical rehabilitation required due to the Insured Person's Covered Loss or Injury;
2. meets generally accepted standards of medical practice;
3. is performed under the care, supervision or order of a Physician; and
4. prepares the Insured Person to return to His or any other occupation.

Exclusions

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

REPATRIATION BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person suffers Loss of Life due to a Covered Loss while outside a 100 mile radius from His current place of primary residence. The Company will pay for Covered Expenses reasonably incurred to return His body to His current place of primary residence.

Covered Expenses include, but are not limited to, expenses for: (1) transportation of the remains by the most direct and economical Conveyance and route possible; or (2) 100% of the Usual and Customary Charges.

AXIS's travel assistance service provider must make all arrangements and must authorize all expenses in advance for this Benefit to be payable. However, the Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact **AXIS's travel assistance service provider** in advance.

Exclusions

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

SEATBELT AND AIRBAG BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, when the Insured Person's death results from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in a Private Passenger Automobile. An additional benefit is provided if the Insured Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Insured Person's claim to the Company.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.

Definitions

For purposes of this Benefit:

Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas or a child safety device.

Exclusions

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

HIPAA PRIVACY NOTICE

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

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

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

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

YOUR HIPAA PRIVACY RIGHTS

Access to Your PHI

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

Amendments to Your PHI

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

Accounting for Disclosures of Your PHI

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

Restrictions on Uses and Disclosures of Your PHI

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

Confidential Communication of PHI

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

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

Potential Impact of Other Applicable Laws

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

Complaints

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

Contact Information

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

Administrative Address:
AXIS Insurance Company
1 University Square Drive, Suite 200
Princeton, NJ 08540
888.870.AXIS (2947)
General questions - please send to USSales.AccHealth@axiscapital.com

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

Effective June 1, 2011

OFAC NOTICE

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