BLANKET ACCIDENT POLICY/CERTIFICATE

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:
303 W. Madison Street, Suite 500
Chicago, IL 60606

POLICYHOLDER: Bioventus, LLC

POLICY NUMBER: BTAB-50364-353

POLICY EFFECTIVE DATE: December 01, 2012

POLICY ANNIVERSARY DATE: May 4

POLICY TERM: May 04, 2015 through May 3, 2018

STATE OF ISSUE: North Carolina

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

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

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

Secretary

President

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 IS NOT A MEDICARE SUPPLEMENT POLICY
PLEASE READ YOUR POLICY CAREFULLY
NON-PARTICIPATING

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

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SCHEDULE OF BENEFITS

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

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

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

	Principal Sum
Class 1 All full-time exempt, non-exempt employees and and part-time employees of the Policyholder.	5 times the Insured Person's Basic Earnings to a maximum of $500,000
Class 2 All full-time and part time employees at Director Level and above of the Policyholder.	5 times the Insured Person's Basic Earnings to a maximum of $500,000
Class 3 All expatriate employees of the Policyholder, as reported to the Company.	5 times the Insured Person's Basic Earnings to a maximum of $500,000

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

Class 1 and 2 Only
BUSINESS TRAVEL INSURANCE COVERAGE

Personal Deviations covered	yes
Maximum Length of Personal Deviation	14 days

Class 3 Only
24-HOUR BUSINESS AND PLEASURE COVERAGE

Class 1, 2 and 3
WAR RISK COVERAGE

BENEFITS

Aggregate Limit of Indemnity

Applies to:	**Benefit Amount**
All Conditions of Coverage Air Only (except War Risk)	$2,500,000
War Risk Coverage	$2,500,000

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss must occur within	365 days of the Covered Accident
Benefit	**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
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	25% of the Principal Sum
Exposure and Disappearance	**Included**

BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

Counseling must occur within	365 days of the Loss of Life or Covered Loss
Benefit Amount	$150 per session
Maximum Number of Sessions	10
Maximum Benefit per Covered Loss	$1,500

CARJACKING BENEFIT

Covered Loss must occur within	365 days of the Covered Accident
Benefit Amount	10% multiplied by the portion of the Benefit Amount applicable to the Covered Loss as shown in the Schedule of Accidental Death and Dismemberment Benefits multiplied by the portion of the Benefit Amount applicable to the Covered Loss, as shown in the Schedule of Accidental Death and Dismemberment Benefits subject to a Maximum Benefit of $25,000

COBRA MEDICAL INSURANCE CONTINUATION EXPENSE BENEFIT

Benefit Amount	$3,000 per policy year
Maximum Benefit Period	36 months

COMA BENEFIT

Covered Loss must occur within	30 days of the Covered Accident
Benefit Amount	1% of the Principal Sum for the first 11 months, 100% in the 12th Month

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

Benefit Amount	10% of the Principal Sum subject to a Maximum Benefit of $25,000

MEDICAL EVACUATION BENEFIT

Benefit Amount	
Medical Evacuation Benefit	100% of Usual and Customary Charges

REPATRIATION BENEFIT

Benefit Amount	
Repatriation Benefit	100% of Usual and Customary Charges

PARALYSIS BENEFIT

Covered Loss must occur within	365 days of the Covered Accident
Benefit Amount	
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum

REHABILITATION BENEFIT

Covered treatment must occur within	365 days of the Covered Accident
Benefit Amount	10% of the Principal Sum subject to a Maximum Benefit of $25,000

SEATBELT AND AIRBAG BENEFIT

Benefit Amount	
Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of $50,000
Airbag Benefit	10% of the Principal Sum subject to a Maximum Benefit of $25,000
Default Benefit	$1,000

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:

$3,763 per year, due and payable in annual installments with the first installment due as of the Policy Effective Date and subsequent installments due as of each Policy Anniversary Date.

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	Three-Year Annual Installments
Premium Due Date	Policy Effective Date and each Policy Anniversary Date thereafter
Initial Premium (paid)	$2,433
December 01, 2012 through May 3, 2013	$598.82

Contributions - The cost of coverage is paid by the Policyholder, Minimum and Deposit premiums are fully earned and non-refundable**.** All Benefits and Conditions of Coverage cannot vary among Eligible Persons in any covered class.

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.

Active Service means the Insured Person will be considered in Active Service with His Employer on any day that is either of the following:

1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than sick leave, only if the Employee was in Active Service on the preceding scheduled workday.

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.

Basic Earnings means your annual compensation from your Employer.

Basic Earnings includes:

- your average annual rate of compensation from your Employer including:
  - average annual salary;
  - regular hourly wages (but not for more than 40 hours a week); or
  - commissions averaged over the preceding 12 months or the period of your employment if less than 12 months

Basic Earnings does not include:

- bonuses;
- overtime pay;
- extra compensation;
- your Employer's contributions on your behalf to any deferred compensation plan or pension plan;
- income you earn as a private contractor on IRS Form 1099; or
- stock options

If the Insured Person is a commissioned sales person, Basic Earnings will be any salary or wages and commissions received from the Employer. This will be based on the Statement of Wages Earned and Taxes Withheld (Form W-2) for the fiscal year ending immediately prior to the date of the Insured Person's death.

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

Civilian Aircraft means a civil or public Aircraft having a valid Airworthiness Certificate and piloted by a person who has a current and valid medical certificate and pilot certificate with appropriate ratings for the Aircraft. A Civilian Aircraft does not include a Policyholder Aircraft.

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:
1. takes place under one of the Conditions of Coverage specified in the *Schedule of Benefits;* and
2. is sponsored, organized, scheduled or otherwise provided by the Policyholder.

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, and (2) which results directly and independently from all other causes from a Covered Accident and (3) which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Covered Loss

means a loss which meets the requisites of one or more benefits, and results from a Covered Accident, Covered Injury or Covered Activity.

Dependent Child

means the Insured Person's unmarried child who meets the following requirements.
1. a child from birth to 26 years old;
2. a child who is 26 or more years old but less than 30 years old, enrolled in a school as a full-time student and primarily supported by the Insured Person. Coverage will continue during any period between school terms or school years as long as the Company is provided satisfactory proof that He has enrolled for the next following school term or year; or
3. a child who is 26 or more years old, primarily supported by the Insured Person, and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the Company within 31 days after the date the child ceases to qualify as a Dependent Child for the reasons listed above. During the next two years, the Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Company may require proof no more than once a year.

A Dependent Child, for purposes of this definition, includes the Insured Person's:
1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. stepchild or foster child; and
4. child for whom the Insured Person is legal guardian.

If an Insured Person is required by a court or administrative order to provide health benefit plan coverage for a Dependent Child, and the Insured Person is eligible for family health benefit plan coverage through the Company, the Company will :
(1) allow the Insured Person to enroll, under the family coverage, a Dependent Child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
(2) enroll the Dependent Child under family coverage upon application of the Dependent Child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the Insured Person is enrolled but fails to make application to obtain coverage for the Dependent Child.
(3) not disenroll or eliminate coverage of the Dependent Child unless the Company is provided satisfactory written evidence that:
a. The court or administrative order is no longer in effect; or
b. The Dependent Child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

If a Dependent Child has health benefit plan coverage through the Company of a noncustodial parent, the Company shall do all of the following:
(1) Provide such information to the custodial parent as may be necessary for the Dependent Child to obtain benefits through that coverage.
(2) Permit the custodial parent (or the health care provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent.
(3) Make payments on claims submitted in accordance with subdivision (2) of this subsection directly to the custodial parent, the provider, or the Department of Health and Human Services.

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

Employer means the Policyholder and any affiliates, subsidiaries or divisions shown in the Master Policy covered under this Policy on its effective date or a later date agreed to by the Company.

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

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

Hospital Confined or 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 or Emergency Sickness 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, domestic partner, brother-in-law, sister-in-law, daughter -in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

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

Insured Person means an Eligible Person, as defined in the *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 Covered Accident 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.

Military Air Transport means an Aircraft having a current and valid Airworthiness Certificate; piloted by a person who has a current and valid medical certificate and pilot certificate with appropriate ratings for the Aircraft; and operated by the United States of America, or by the similar air transport service of any duly constituted governmental authority of any recognized country.

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.

Outpatient means an Insured Person who is a patient and is not hospitalized overnight but who visits a Hospital, clinic, or associated facility for diagnosis or treatment.

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 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.

Policyholder Aircraft means any Aircraft with a current and valid Airworthiness Certificate and owned, leased, operated or controlled by the Policyholder.

Policy Term	means the time period defined for the Policyholder shown in the *Schedule of Benefits.*
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.
Personal Deviation	means non-business travel or activities undertaken While on the Business of the Policyholder but unrelated to furthering the business of the Policyholder which: 1. is neither reasonably related to or incidental to the purpose of travel for which coverage is provided by this Policy; and 2. the Insured Person performs before, during or after covered travel. When coverage is provided during a Personal Deviation, the time period covered is shown in the Conditions of Coverage section of the *Schedule of Benefits.* A Personal Deviation does not include extension of a business trip authorized in advance by the Policyholder as necessary to reduce transportation costs.
Spouse	means the Insured Person's lawful Spouse.
Trip	means a Trip taken by an Insured Person which begins when the Insured Person leaves His residence or place of regular employment for the purpose of going on the Trip (whichever occurs last), and is deemed to end when the Insured Person returns from the Trip to His residence or place of regular employment (whichever occurs first). However, the Trip is deemed to exclude any period of time during which the Insured Person is on an authorized leave of absence or vacation or travel to and from the Insured Person’s place of regular employment.
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.
While on the Business of the Policyholder	means while on assignment by or at the direction of the Policyholder for the purpose of furthering the business of the Policyholder, but does not include any period of time: (1) while the Insured Person is working at His regular place of employment; (2) during the course of everyday travel to and from work; or (3) during an authorized leave of absence or vacation.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

Deferred Effective Date

The Effective Date of insurance will be deferred for an Eligible Person who is not in Active Service on the date insurance would otherwise become effective. Insurance will become effective on the later of the date He returns to Active Service and the date insurance would otherwise have become effective.

Effective Date for Individuals

Insurance becomes effective for the Eligible Person, subject to the Deferred Effective Date provision above, on the latest of the following dates:

1. the Policy Effective Date; and
2. the date the person becomes eligible.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

Effective Date for Newly-Acquired Affiliates

Insurance becomes effective for any newly-acquired affiliate of the Policyholder on the date it is acquired if the Company has been notified in writing within 30 days and has agreed to provide insurance, and additional premium has been paid when due. If the Company is not notified within the required time period, insurance for the affiliate will become effective on the date the Company agrees in writing to insure it and receives any additional premium due. Individuals who are employees of an affiliate on its effective date of insurance under this Policy will be eligible for insurance on that date.

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 change. Increases will take effect subject to any Active Service requirement.

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.

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 date the person enters full time active duty in any Armed Forces. The Company will refund any premium paid for any period of active duty when the Company receives proof of active duty. Active duty does not include Reserve or National Guard duty for training unless it extends beyond 31 days;
3. the end of the period for which the last premium is made; or
4. the date this Policy ends.

Termination does not affect a claim for a Covered Loss due to a Covered Accident or Emergency Sickness 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 coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided in the Description of Benefits Section or the Conditions of Coverage Section:

1. Intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
4. A Covered Accident or Emergency Sickness that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, the Company will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
5. Flight in, boarding or alighting from, an Aircraft or any craft designed to fly above the Earth's surface:
    a. except as a fare-paying passenger on a regularly scheduled commercial airline;
    b. being flown by the Insured Person or in which the Insured Person is a member of the crew;
    c. being used for:
        i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
        ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    d. designed for flight above or beyond the earth's atmosphere;
    e. including an ultra-light or glider;
    f. being used for the purpose of parachuting or skydiving;
    g. being used by any military authority, except an Aircraft used by the air mobility command or its foreign equivalent;
6. Travel in any Aircraft owned, leased, operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. Medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice;
9. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
10. Operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

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

CLAIM PROVISIONS

Beneficiary

The beneficiary, unless the Insured Person specifies otherwise as provided below, will be the person He has named as beneficiary of any group life insurance, or if none is in force, of any group Accident insurance, provided by the Policyholder.

The beneficiary is the person or persons the Insured Person names or changes on a form executed by Him and satisfactory to the Company. This form may be in writing or by any electronic means agreed upon between the Company and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

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

If more than one person is named as beneficiary, the interests of each will be equal unless the 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;
5. estate of the Insured Person.

Claim Forms

The Company 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 within 30 days after the occurrence or commencement of the Insured Person's Covered Loss, Emergency Sickness or as soon thereafter as reasonably possible. Notice must be given by or on behalf of the claimant to the Company to its designated authorized agent, with information sufficient to identify the Insured Person, or to any authorized agent of the Company, 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 Claims Provisions.

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

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

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

Time of Payment of Claims

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

Payment of Claims To Foreign Employees

The Policyholder may, in a fiduciary capacity, receive and hold any benefits payable to an Insured Person whose place of employment is other than:

1) The United States of America;
2) Puerto Rico; or
3) The Dominion of Canada.

The Company will not be responsible for the application or disposition by the Policyholder of any such benefits paid. The Company's payments to the Policyholder will constitute a full discharge of the Company's liability for those payments under this Policy.

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 3 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 180 days after the date of the Covered Loss or Emergency Sickness. In the case of a claim for loss of time for disability, written proof of such loss must be furnished to the Company within 180 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.

ERISA Claims

The Policyholder agrees that the Policy constitutes the plan and plan document under the Employee Retirement Security Act of 1974 as amended (ERISA). The Policyholder designates the Company, or a person or persons which the Company designates, as the claims fiduciary of this plan and gives the Company, or its designee, the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The Policyholder agrees to comply with the disclosure and reporting requirements of ERISA regarding the plan and the Company's designation and authority as claims fiduciary.

ADMINISTRATIVE PROVISIONS

Cancellation

The Company or the Policyholder may cancel this Policy after the first year or Policy Term, as of any Premium Due Date, by giving the other party 45 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 *Schedule of Benefits*.

Cancellation does not affect a claim for a Covered Loss when the Covered Loss 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 premiums for this Policy will be based on the rates set forth in the Rate Table, the plan and amounts of insurance in effect for Insured Persons and the premium mode selected, as shown in the *Schedule of Benefits*. The Company will provide notifications of premiums due or premium changes, by mail 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 *Schedule of Benefits*, 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 mailed 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 one of the following occurs:

1. the terms of this Policy change;
2. the number of Insured Persons or Eligible Persons for coverage increases or decreases by more than 10% since the later of the Policy Effective Date and the date of the last renewal of this Policy;
3. coverage is reinstated following failure to pay premium during the Grace Period;
4. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of Eligible Person or Insured Persons;

5. a change in Insured Persons or Eligible Persons to be covered which would, on a manual rate basis, require a change of 10% or more in the premium rate;
6. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this Policy;
7. the Policyholder fails to provide sufficient information, as required by the Company, to confirm adequacy of premiums and rates currently being paid.

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.

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.

Certificates

Where required by law, the Company will provide a certificate of insurance for delivery to the Insured Person. Each certificate will set forth a statement as to the insurance coverage to which the Insured Person is entitled, to whom the insurance benefits are payable, and a statement as to any family member, Spouse or Dependent's coverage. If family members or Dependents are included in the coverage, the insurer need only issue one certificate to each family unit.

Clerical Error

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

Conformity with Statutes

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

Entire Contract; Changes

The Policy 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.

CONDITIONS OF COVERAGE

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

BUSINESS TRAVEL INSURANCE COVERAGE

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 one of the Covered Travel Activities described below and while the Insured Person is travelling:

1. While on the Business of the Policyholder;
2. in the course of the business of the Policyholder;
3. on a Trip authorized in advance by the Policyholder;
4. away from the premises of the Policyholder;

Covered Travel Activities also include commuting directly between home and the Policyholder's premises where the Insured Person normally works, while using an alternative means of transportation necessitated by discontinuance of service, strike or major breakdown of one or more Public Conveyance transportation systems which the Insured Person normally uses.

Definitions

For purposes of this Condition of Coverage:

Personal Deviation means

1. an activity that is not reasonably related to the Policyholder's business;
2. not incidental to the purpose of the Trip;
3. such travel or activities coincide with an Insured Person's business travel; and
4. Personal Deviation is limited to any consecutive 14 days period immediately prior to, during or following such business travel.

Exclusions

Coverage for business travel is not provided during any of the following:

1. normal commuting between the Insured Person's home and place of work;
2. travel to another location where the Insured Person is expected to be assigned for more than 365 days;
3. any activity not authorized or organized, or not reimbursable, by the Policyholder;
4. the Insured Person's participation in any race or speed contest;
5. the Insured Person's driving any vehicle or Private Passenger Automobile for pay or hire.

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

24-HOUR BUSINESS AND PLEASURE COVERAGE

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

Exclusions

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

WAR RISK COVERAGE

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 (but not such act in which the Insured Person is an active participant) that occurs during war or an act of war that occur:

1. Worldwide, excluding: the United States and its territories and possessions and the Insured Person's country of permanent residence and Afghanistan, Iraq, and Libya;
2. While on the Business of the Policyholder

The Policyholder may cancel this War Risk Coverage at any time by sending written notice to the Company at the Company's home office address. Coverage will be canceled upon receipt of notice or a date specified by the Policyholder.

The Company may cancel this coverage at any time by providing written notice to the Policyholder at least 10 days prior to termination of this coverage. Any unearned premium will be promptly returned to the Policyholder.

Definitions

For purposes of this Condition of Coverage:

Designated War Risk Territory(ies) –means all countries except those excluded above in item 1.

Changes in Premium. The Company may change the premium rate for the inclusion of War Risk Coverage under this Policy at any time if (1) war risk conditions change in the Designated War Risk Territory(ies); (2) there is a change in which area(s) is (are) defined to be the Designated War Risk Territory(ies); or (3) the Policyholder's exposure to war risk in the Designated War Risk Territory(ies) changes in any way. The Company will give the Policyholder written notice of any change in the premium rate for the inclusion of War Risk Coverage at least 10 days in advance of the effective date of the change.

Changes in Terms and Conditions. The terms and conditions of War Risk Coverage, including but not limited to the definition of the Designated War Risk Territory(ies), may be changed at any time, to reflect conditions that, in the opinion of the Company, constitute a change in the Policyholder's war risk exposure.

Exclusions

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

DESCRIPTION OF BENEFITS

This Description of Benefits Section describes the Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits.* Please read these and the Common Exclusions sections 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 Covered 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 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 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 of the body.

Exclusions

Voluntary exposure, upon release, to nuclear energy or radiation, including sickness or disease resulting from such release**.**

Other 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 and/or Immediate Family Member or Fellow Participant requires bereavement and trauma counseling because of an Accidental Death or Covered Accident under this policy. Such counseling must meet all of the following conditions:

1. covered bereavement and trauma counseling expenses must be incurred within 365 days from the date of the Covered Loss;
2. the expense is charged for a bereavement or trauma counseling session for the Insured Person and/or one or more of His Immediate Family Members or Fellow Participants;
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.

Definitions

For purposes of this benefit:

Fellow Participant means an Insured Person, other than the Insured Person who suffered a Covered Loss, who was present at or participating in the same Covered Activity and as a result suffered trauma requiring counseling treatment.

Exclusions

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

CARJACKING 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 during a Carjacking of a Private Passenger Automobile that the Insured Person was operating, getting into or out of, or riding in as a passenger. Verification of the Carjacking must be made part of an official police report within 24 hours of the Carjacking, or as soon as reasonably possible,, or be certified in writing by the investigating officer(s) within 24 hours or as soon as reasonably possible.

Definitions

For purposes of this benefit:

Carjacking means a person other than the Insured Person taking unlawful possession of a Private Passenger Automobile by means of force or threats against the person(s) then rightfully occupying it.

Exclusions

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

COBRA MEDICAL INSURANCE CONTINUATION EXPENSE BENEFIT

The Company will pay the Benefit Amount shown in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if a surviving Spouse or a surviving Dependent Child elects to continue group medical, dental or vision insurance provided by the Employer of the Insured Person who died and benefits were payable under this Policy, subject to all applicable conditions and exclusions if all of the following conditions are satisfied:

1. the Insured Person's death results directly and independently of all other causes from a Covered Accident;
2. the Insured Person is survived by a Spouse or Dependent Child;
3. a Spouse or Dependent Child is also covered under a medical, dental or vision plan sponsored by the Insured Person's Employer at the time of His death;
4. a Spouse or Dependent Child notifies the Company of His election, within 60 days of the Insured Person's death, to continue His existing coverage under group insurance plans sponsored by the Employer as permitted by state or federal continuation law.

This benefit, payable annually, equals premiums required to continue insurance described above, as long as the total of Insurance Continuation Benefits paid for a surviving Spouse or surviving Dependent Child do not exceed the Benefit Amount shown in the *Schedule of Benefits*. The benefit will be paid at the end of each year during which medical, dental, or vision insurance is continued, if the Company receives the request for reimbursement and proof of premiums paid during that year.

Benefits will continue to be paid until the earliest of the following dates:

1. the date a surviving Spouse or surviving Dependent Child is no longer eligible to continue medical and/or dental and/or vision insurance coverage;
2. the date Insurance Continuation Expense Benefits paid total the Benefit Amount shown in the *Schedule of Benefits*; or
3. the end of the Maximum Benefit Period.

Benefits are payable to the surviving Spouse or surviving Dependent Child or the person who actually paid the premium on the surviving Spouse's behalf, if other than the surviving Spouse.

Exclusions

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

COMA BENEFIT

The Company will pay the Coma Benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if an Insured Person becomes comatose or 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 Coma must begin within 30 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 from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Loss.

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.

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 suffers a Covered Injury or an Emergency Sickness that warrants His 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 all Emergency Sicknesses from the same or related causes.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured Person's Covered Injury or Emergency Sickness warrants His Emergency Evacuation. All transportation arrangements made for the Emergency Evacuation must be by the most direct and economical Conveyance and route possible. **AXIS Global Travel Assistance** 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 Global Travel Assistance** 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) Usual and Customary Charges.

Emergency Evacuation - means, if warranted by the severity of the Insured Person’s Covered Injury or Emergency Sickness: (1) the Insured Person's immediate transportation from the place where He suffers a Covered Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Insured Person's transportation to His current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering a Covered Injury or Emergency Sickness 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.

Emergency Sickness - means an illness or disease diagnosed by a Physician which:

1. causes a severe or acute symptom that, if not provided with immediate treatment, would reasonably be expected to result in serious deterioration of the Insured Person's health or place His life in jeopardy; and
2. first manifests itself suddenly and unexpectedly while the Insured Person is covered under this policy.

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

REPATRIATION BENEFITS

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 or Emergency Sickness 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) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical Conveyance and route possible; or (4) Usual and Customary Charges.

AXIS Global Travel Assistance 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 Global Travel Assistance** in advance.

Definitions For purposes of this benefit:

Emergency Sickness - means an illness or disease diagnosed by a Physician which:

1. causes a severe or acute symptom that, if not provided with immediate treatment, would reasonably be expected to result in serious deterioration of the Insured Person's health or place His life in jeopardy; and
2. first manifests itself suddenly and unexpectedly while the Insured Person is covered under this policy.

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

PARALYSIS BENEFIT

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

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

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.

If such certification or police report is not available or it is unclear whether the Insured Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, the Company will pay a default benefit shown in the *Schedule of Benefits* to the Insured Person's beneficiary.

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.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of North Carolina who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the guaranty association is not unlimited, however. And, as noted below, *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may or may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations and exclusions and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for a policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
PO Box 10218
Raleigh, North Carolina 27605

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the next page* is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FOR COVERAGE

However, persons holding such policies are not protected by the association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy for a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); and
- unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNTS OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.

(3) Except as provided in (4) and (5) below, the guaranty association will pay an aggregate maximum of $500,000 with respect to any one individual affected by multiple insolvencies.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to any one structured settlement annuity contract holder.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.