GROUP ACCIDENT CERTIFICATE

Underwritten by:
AXIS INSURANCE COMPANY
111 South Wacker Drive, Suite 3500, Chicago, IL 60606
A Stock Company
(Herein called the Company)

CERTIFICATE OF INSURANCE
AXIS Insurance Company (the Company) certifies that certain eligible persons are insured for the benefits described in this certificate. This insurance is subject to the eligibility and effective date requirements described in the **ELIGIBILITY** section of this certificate.

The date insurance is to take effect might not be a scheduled workday. If so, you will be considered Actively At Work on such date if you were Actively At Work on your last scheduled workday. You are considered Actively At Work:

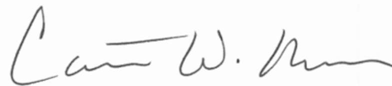
- during your normal vacation time provided by your Employer;
- during jury duty;
- on any holiday, or day of the weekend, and
- on any day of an excused leave approved by your Employer.

IMPORTANT NOTICE
This certificate is a summary of the group policy provisions that affect your insurance. It is merely evidence of the insurance provided by such policy for Independent Pool & Spa Service Association, Inc. (IPSSA) (the Policyholder).

The group policy is a contract between the Company and the Policyholder. It may be changed or ended without notice to or consent of any Insured Person. This certificate replaces any certificate previously issued by the Company to you under the group policy. The benefits described in this certificate are provided by group policy no. **SRPOHIR3100001-00**

The Company is providing this electronic version of the certificate at the request of the Policyholder. The Policyholder maintains the group policy, which includes a copy of the certificate. The group policy is available for you to review and copy. If there is any conflict between the information in this electronic version of the certificate and the group policy, the group policy will control in all respects.

RIGHT TO EXAMINE CERTIFICATE. The certificate issued to each Insured Person can be returned for any reason within 31 days after it is received by the Insured Person. The certificate should be returned by mail or in person to the Company. Any premium paid will be refunded and the certificate will be treated as if it were never issued.



Secretary President

GROUP ACCIDENT CERTIFICATE
THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY.
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS OR DISEASE.
PLEASE READ THIS CERTIFICATE CAREFULLY
Non-Participating

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SCHEDULE OF BENEFITS

Effective Date of Coverage: April 1, 2021 Policy Anniversary Date: April 1	Eligible Class(es): **"Regular Members" of the Independent Pool & Spa Service Association ("IPSSA") who participate in the "IPSSA Endorsed Insurance Program" and for whom premium is paid. No coverage is provided for any "Employee Member" as defined by IPSSA's Bylaws, Standing Rules and Policies & Procedures.**
Policyholder Scheduled Enrollment Period: April 1, 2021	Open Enrollment Effective Date: April 1, 2021

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

Eligible Persons: An Eligible Person is a regular member of the Policyholder. An employee member is not an Eligible Person.

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

Sponsored Activities Coverage

Education: While attending local scheduled IPSSA chapter meetings in the United States which may include educational opportunities or presentations from Associate Members of the Policyholder. Industry events are excluded.
Sick Route Support: While on the United States job site to provide pool or spa service of a different IPSSA member’s route.
Job Site: While on the United States job site to provide pool or spa service of the member’s own route.

Policy Individual Maximum $5,000
Applies to All benefits provided by this Policy Certificate to any one Insured Person for Covered Losses or Covered Injuries sustained and Covered Expenses in any one Covered Accident

Policy Aggregate Maximum $200,000
Applies to All benefits provided by this Policy; Benefits agreed to by us and the Policyholder.

Not more than the Policy Aggregate Maximum specified above will be paid for all Covered Losses, Covered Accidents, Covered Injuries and Covered Expenses for all Insured Persons as the result of any one Covered Loss, Injury or Accident. 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 Policy Aggregate Maximum.

ACCIDENT DEATH BY ACCIDENTAL MEANS AND DISMEMBERMENT BENEFITS

Loss must occur within	365 days of the Covered Accident
Insured Person Principal Sum	$5,000

Schedule of Covered Losses

Loss	**Benefit Amount**
Death by Accidental Means	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of 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 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 BENEFIT Included

ACCIDENT MEDICAL BENEFIT

Scope of Coverage Applicable to Accident Medical Benefits

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

Full Excess Medical Expense

Covered Expenses	**Benefit Percentage/Amount and Other Limits**
The amount of each Covered Expense where applicable will be the Usual and Customary Charge.	
Total Maximum for all Accident Medical Benefits	$5,000
First Covered Expenses must be Incurred within	90 days after the Covered Accident
Benefit Period	52 weeks from the date of the Covered Accident
Deductible	$100
applies to	each Policy Year
Deductible must be Satisfied within	365 days from the date of the Covered Accident

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

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

Eligibility
A member becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits*.

Effective Date for Individuals
Insurance becomes effective for an eligible member who applies within 31 days of the date he becomes eligible and, subject to the Deferred Effective Date provision below, on the latest of the following dates:
1. the effective date of this Policy;
2. the date the member becomes eligible;
3. the date the Company receives the member's completed enrollment form during his lifetime.

The Company may, from time to time, require the member to re-enroll using forms supplied by the Company to keep his insurance in force.

DEFERRED EFFECTIVE DATE

Active Service
The effective date of insurance will be deferred for any member who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date he returns to Active Service and the date coverage would otherwise have become effective.

Active Service/Actively at Work
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 or part-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;
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.

DATE INSURANCE ENDS

Insured's Termination Date. An Insured's coverage under the Policy will end on the earliest of the following dates:

1. the premium due date, if premiums are not paid when due (subject to the grace period);
2. at the end of the month following the date the Insured ceases to be a member of an Eligible Class;
3. the date the Policy terminates; or
4. the date of the Insured's 80th birthday; or
5. the date the Insured notifies the Company in writing to discontinue his or her coverage**.**

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

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 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.

Economic Sanctions Provision

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the Company from providing insurance, including, but not limited to, the payment of claims.

Notice of Claim

Written notice of claim must be given to the Company within 20 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 at USClaims.AccHealth@axiscapital.com, or to any authorized agent of the Company 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.

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 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.

Proof of Loss

Written proof of loss must be furnished to the Company within 90 days after the date of the Covered Loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as 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.

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

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 payment is made to the estate of the Insured Person or to any payee who is a minor or is not competent to give a valid release the 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 is deemed equitably entitled thereto.

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

Claimant Cooperation Provision

Failure of a claimant to cooperate with the Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Conditional Claim Payment

If the Insured Person incurs expenses for Injuries received in a Covered Loss and in the Company's 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 90 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought after expiry of the applicable statute of limitations from the time proof of loss is required to be furnished under this Policy.

Physical Examination And Autopsy

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

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 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.

Recovery of Overpayment

If benefits are overpaid, the Company has the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Insured Person dies, the Company may recover the overpayment from the Insured Person's estate.

ADMINISTRATIVE PROVISIONS

Cancellation

The Company or the Policyholder may cancel this Policy after the first year 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 *Schedule of Benefits*.

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

Premium Rate Changes

The Company may change premium rates at the end of any Policy Term or any Premium Rate Guarantee Period with at least 31 days advance notice 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. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 25% or more the number of Insured Persons;
3. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this Policy;

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

Refund of Premium

The Company will refund any premium paid for coverage of a specified Covered Activity if:
1. that Covered Activity is cancelled; and
2. the Policyholder notifies the Company in writing at least 7 days before the Covered Activity was scheduled to take place.

No insurance will be in effect for any Insured Person while he participates in, travels to, attends or otherwise is involved in the Covered Activity. If this Policy was issued to insure only the Covered Activity that was cancelled, and the Company was notified as required in 2. above, this Policy will be void from its inception.

GENERAL PROVISIONS

Addition of New Members

All Members added to the Classes of Eligible Person's in the *Schedule of Benefits* are eligible for insurance under this Group Policy.

Assignment

The rights and benefits under this Policy may not be assigned and any 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.

30 Day Right to Examine Certificate

If the Insured Person does not like the Certificate for any reason, it may be returned to the Company within 30 days after receipt. The Company will return any premium that has been paid. In that case the Certificate will be void as if it had never been issued.

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, the Master Application and any attached papers make up the entire contract between the Policyholder and the Company. In the absence of fraud, any statements made by the Policyholder or any Insured Person will be considered representations and not warranties. No such statement shall avoid the insurance or reduce the benefits under this Policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void this policy after it has been in force for three years from the date of its issue, nor shall any such statement of any Insured Person eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the policy) commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

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.

If an enrollment form for an Insured Person is required, it may also be made a part of this Policy at the Company's option.

Examination of the Policy

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

Time Limit on Certain Defenses

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

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's 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 Insurance 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;
4. Additional information required by The Company.

The Company may 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.

SPONSORED ACTIVITIES COVERAGE

The Company will the 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 while the Insured Person is participating in or attending a Sponsored Activity(ies).

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

DESCRIPTION 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.

ACCIDENT DEATH BY ACCIDENTAL MEANS 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 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.

If a Covered Loss causes the Insured Person's death, the Company will pay for Death by Accidental Means and any other Covered Losses will not exceed the Principal Sum, Death by Accidental Means Benefit, largest Benefit payable for a Covered Loss.

EXPOSURE AND DISAPPEARANCE BENEFIT

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 Death by Accidental Means 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 Death by Accidental Means that would have been payable under the Policy.

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

Definitions For purposes of this benefit:

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

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

Loss of 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 metatarsal phalangeal joint.

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

Physician means a United States licensed health care provider practicing in the United States within the scope of his license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:
1. the Insured Person;
2. a parent, sibling, spouse or child 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.

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

ACCIDENT MEDICAL BENEFIT

Covered Expenses and any applicable Deductibles are shown in the *Schedule of Benefits.*

Other Health Care Plan Benefits

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

Full Excess Medical Expense

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

Any Covered Expenses payable under this provision will be reduced by the Other Health Care Plan Reduction Percentage shown in *Schedule of Benefits* or the amount the Health Care Plan would have paid had its services or facilities been utilized if:
1. the Insured Person has coverage under another Health Care Plan; and
2. the Other Health Care Plan is an HMO, PPO or similar arrangement; and
3. the Insured Person does not use the facilities or services of the HMO, PPO or similar arrangement.

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

ACCIDENT MEDICAL BENEFITS (continued)

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

Benefits will be paid:

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

COVERED EXPENSES:

In-Patient Hospital Services

Room and Board Expenses

The Company will pay for:

1. confinement in an intensive care unit, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of such confinement;
2. any other confinement, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of the Hospital Stay.

Miscellaneous Expenses:

The Company will pay the Miscellaneous Expenses charged by a Hospital or ambulatory surgical center for outpatient surgery. Miscellaneous Expenses include, but are not limited to, X-ray, laboratory, in-hospital physiotherapy, orthopedic appliances, pre-admission tests and all necessary charges other than room and board, for services received during a Hospital Stay.

Ambulatory Medical Center

The Company will pay Covered Expenses incurred for medical or surgical treatment provided in a licensed facility providing ambulatory surgical or medical treatment that is not a Hospital or Physician's office.

Emergency Room Treatment

The Company will pay Covered Expenses incurred for outpatient emergency room treatment performed in a Hospital, up to the Maximum Benefit shown in the *Schedule of Benefits.* When emergency room treatment is immediately followed by admission to a Hospital, such treatment will be a Hospital Covered Expense.

Physician Services

The Company will pay Covered Expenses incurred for Physician Services listed below.

Surgery –

1. Covered Expenses charged for performing a surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure and
2. Covered Expenses charged by an assistant surgeon assisting a Physician performing a surgical procedure.
3. Covered Expenses charged for treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including aftercare, which is given in the outpatient department of a Hospital or an ambulatory surgical center.
4. Any braces, splints or other devices required after surgery to ensure proper healing.

Use of Physician's Surgical Facilities – Covered Expenses charged for the use of the Physician's surgical facilities.

Second Opinion or Consultation – Covered Expenses charged by a Physician for a second surgical opinion, or consultation.

Physician's Assistant – Covered Expenses charged by a Physician's Assistant for other than pre- or post-operative care, second opinion or consultation:
1. for in-Hospital visits; and
2. for office visits.

Anesthesia and its Administration – Covered Expenses charged by a Physician for anesthesia and its administration.

In-Hospital or Office Visits – Covered Expenses charged by a Physician for other than pre- or post-operative care, second opinion or consultation:
1. for in-Hospital visits; and
2. for office visits.

Out-Patient X-Ray, CT Scan, MRI and Laboratory Tests

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

Out-Patient Physiotherapy

The Company will pay Covered Expenses incurred for out-patient Physiotherapy. Physiotherapy means: (a) acupuncture; (b) microthermy; (c) chiropractic adjustment; (d) manipulation; (e) diathermy; (f) massage therapy; (g) heat treatment; and (h) ultrasonic treatment.

Out-Patient Nursing Services

The Company will pay Covered Expenses incurred for out-patient services rendered by a Nurse.

Ambulance Services

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

Medical Equipment Rental

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

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

Medical Services and Supplies

The Company will pay Covered Expenses incurred for:
1. blood and blood transfusions, including processing and administration; and
2. cost and administration of oxygen and other gases.

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

Dental Services

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

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

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

Covered Expenses must be incurred within the Benefit Period shown in the *Schedule of Benefits*. If there is more than one way to treat a dental problem, The Company will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

Prescription Drugs

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

Definitions

For purposes of this Benefit:

Benefit Period means a period, shown in the *Schedule of Benefits* and commencing with the date of the first Covered Expense Incurred for treatment of an Injury sustained in an Accident during which benefits are payable.

Covered Expenses means expenses actually incurred by or on behalf of an Insured Person for Medically Necessary treatment, services and supplies covered by this Policy. Coverage under the Policyholders' Policy must remain continually in force from the date of the Covered Accident until the date of treatment, services or supplies are received for them to be a Covered Expense. 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.

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

Hospital Stay 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 Injury will be treated as one Hospital Stay unless separated by at least 30 days.

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

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.

Medically Necessary means medical services that: (1) are essential for diagnosis, treatment or care of the Injury or Accident 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 or her care, supervision or order.

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

Other Health Care Plan means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for healthcare, dental care disability benefits or repatriations of remains. An Other Health Care Plan includes group, blanket, franchise, or family:

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

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.

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

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

EXCLUDED EXPENSES

Excluded Expenses

The following will not be considered Covered Expenses unless coverage is specifically provided.

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

Other Exclusions that apply to this Benefit are in the *Exclusions and Limitations* Section.

In no event will the company's total payments for the Insured Person exceed the Maximum Benefit Amount for the Accident Medical Expense shown in the Schedule of Benefits.

EXCLUSIONS AND LIMITATIONS

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

1. Intentionally self-inflicted injury, suicide or any willful attempt thereof.
2. Any loss to which a contributing cause was the Insured Person's commission or attempt to commit a felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation.
3. Commission of or active participation in a riot or insurrection.
4. Declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy.
5. Travel in any Aircraft owned, leased 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.
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure to viral, bacterial or chemical agents except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
7. Medical or surgical treatment, diagnostic procedure, administration of anesthesia or medical mishap or negligence, including malpractice unless it occurs during treatment of injuries sustained in a Covered Injury.
8. any loss sustained or contracted in consequence of the Insured Person's being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician.
9. An accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor.

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;
4. the Insured Person.

GLOSSARY

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.

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

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

Covered Injury means accidental bodily injury: (1) which is sustained by an Insured Person as a direct result of an unintended, unanticipated 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 (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a Covered Loss 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 accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Covered Loss means a loss which results from a Covered Accident or Injury and for which benefits are payable under the Policy.

Covered Activity(ies) any recurring 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 and
3. is a Covered Activity.

Dependent Child means the Insured Person's unmarried child who meets the following requirements.

1. A child from live birth to 19 years old.
2. A child who is 19 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.
3. A child who is 19 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 who resides with the Insured Person;
4. Child for whom the Insured Person is legal guardian, as long as the child resides with the Insured Person and depends on him for financial support. Financial support means that the Insured Person is eligible to claim the dependent for purposes of Federal and State income tax returns.

If the Insured Person who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with him for at least six consecutive months and intends to reside with him for an indefinite period of time.

Domestic Partner means a person who:

1. Shares the Insured Person's permanent residence;
2. Has resided with the Insured Person continuously for at least six months and is expected to reside with the Insured Person indefinitely;
3. Is financially interdependent with the Insured Person in each of the following ways:
   a. by holding one or more credit or bank accounts, including a checking account, as joint accountholders;
   b. by owning or leasing their permanent residence as joint tenants;
   c. by naming, or being named by, the Insured Person as a beneficiary of life insurance or under a will;
   d. by each agreeing in writing to assume financial responsibility for the welfare of the other;
4. Has signed a Domestic Partner declaration with the Insured Person, if he resides in a jurisdiction which provides for a Domestic Partner declaration;
5. Has not signed a Domestic Partner declaration with any other person within the last 12 months;
6. Is no less than 18 years of age and not more than 85 years of age;
7. Is not legally permitted to marry the Insured Person;
8. Is not legally married to any other person;
9. Is not a blood relative any closer than would prohibit legal marriage.

In addition to the above requirements, consent of either party due to the Domestic Partner relationship must not have been obtained by force, duress or fraud.

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

Employer 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, You, Yours refers to any individual, male or female.

Hospital 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;
6. it charges for its services.

Hospital shall include a Veteran’s Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an inpatient shall be waived.

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;
3) a Veteran’s Administration Hospital or Federal Government Hospital unless the Insured Person incurs an expense.

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

Insured Person 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.

Nurse 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

Physician a United States-licensed health care provider practicing in the United States 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; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Policyholder 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 in the *Schedule of Benefits.*

Prior Plan means the Group Insurance carried by the Policyholder; on the day before the Policy Effective Date.

Schedule means the Schedule of Benefits section of the Policy.

Spouse means the Insured Person's lawful spouse who is age 18 years and under Age 85**,** who is a United States citizen or has a permanent Alien Registration Card. The term Spouse will include Domestic Partner.

We, Us, Our means AXIS Insurance Company.

You, Your the person to whom the certificate is issued.

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

● **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

● **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

● **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

● Life Insurance

80% of death benefits but not to exceed $300,000

80% of cash surrender or withdrawal values but not to exceed $100,000

● Annuities and Structured Settlement Annuities

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

● **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

● A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract

● A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society

● If the person is provided coverage by the guaranty association of another state.

● Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual

● Employer and association plans, to the extent they are self-funded or uninsured

● A policy or contract providing any health care benefits under Medicare Part C or Part D

● An annuity issued by an organization that is only licensed to issue charitable gift annuities

● 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 certain investment elements of a variable life insurance policy or a variable annuity contract

● Any policy of reinsurance unless an assumption certificate was issued

● Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at *www.califega.org* , or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

CALIFORNIA DISCLOSURE

An Insured Person has the right to request an independent medical review when he or she believes that a Health Care Service has been improperly denied, modified, or delayed by Our Agent or Us.

EXCESS COVERAGE

Benefits payable under this Policy are subject to reduction, to the extent provided in this Policy, if an Insured Person is entitled to benefits, whether on an indemnity basis or on a provision-of-service basis, for hospital, medical, dental, or surgical expenses under any other valid and collectible individual, group, or blanket insurance policy or contract, hospital or medical service program, or group-practice prepayment plan, except for automobile medical payments insurance.

Form CA Notice

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
10000 Avalon Blvd., Suite 200
Alpharetta, GA 30009
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 March 15, 2021

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").