

Our records indicate the Mailing Address for this Insured is as follows:

APPALACHIAN SEARCH AND RESCUE CONFERENCE, INC
PO BOX 400440
CHARLOTTESVILLE, VA 22904-0000

Please note the address of your actual location may be reflected on the declaration page.



*Glatfelter
Insurance
Group*

A Tradition of Service, Founded on Trust.

Dear Valued Client:

Thank you for choosing to insure your members with the VFIS Accident and Sickness Program. We share your interest in providing financial security to emergency responders who are injured in the line of duty.

As required, we are providing you with the Glatfelter Insurance Group (GIG) and AIG privacy notices. VFIS, a division of GIG has underwritten Emergency Service Organizations for nearly 40 years.

Emergency responders are at risk of injury on every call, training and department activities. National events have created awareness in our local communities about these dangers. VFIS remains committed to education and training programs that will prevent or reduce the number of serious incidents.

Please visit vfis.com to access the following:

- **Beneficiary Forms** – review annually to update due to life changes, like marriage. Current beneficiary forms should be retained on file with the department.
- **Claim reports and Attending Physician Statements** – to report injury or illness.
- **Education, Training and Risk Control** programs – utilize for loss prevention.
- **Posters and Literature** – to create awareness and promote safety. Contact Lori Gunderson at 800-233-1957, extension 7291 or at lgunderson@glatfelters.com.
- **Newsletters and Articles** – with valuable information on current topics and events.

The National Volunteer Fire Council and American Addiction Centers created a Firefighter/EMS Assistance Program. We encourage you to take advantage of this service created by and for emergency responders. Support is a phone call away at 888-731-3473 or visit NVFC.org/help for additional information regarding the **Share the Load** campaign.

Thank you for responding to the call for service. We appreciate your business and thank you for insuring with VFIS. Please contact your local agent or VFIS at 800-233-1957.

Sincerely,

Troy Markel, CIC, CRM
President VFIS

Michael A. Baker, CPCU, CRM
Director, VFIS Risk Control



Call Our Confidential Fire/EMS helpline at:

1-888-731-FIRE (3473)

IF YOU SEE NO WAY OUT THEN JUST REACH OUT

MAKE THE CALL TO MAKE THINGS BETTER

Talk to someone you love. Talk to a friend or colleague.
Or, talk to counselors trained and experienced in
the firefighter and EMT culture by calling the national
Fire/EMS Helpline: **1-888-731-FIRE (3473)**.

Find resources to Share the Load at www.nvfc.org/help.

PERSISTENT SADNESS • SUICIDAL THOUGHTS
SUBSTANCE ABUSE • WORK/LIFE STRESSES

The Fire/EMS Helpline is in partnership with American Addiction Centers.
Have questions about the Share the Load™ program? Dial 202-887-5700.



FACTS	WHAT DOES GIG DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal and state laws give consumers the right to limit some but not all sharing. Federal and state laws also require us to tell you how we collect, share and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: <ul style="list-style-type: none"> Name, address, age, Social Security number, marital status, assets, income, credit history, demographic information, IP address, browser information Products or services purchased, account balances and payment history, employment information, motor vehicle reports, medical information
How?	Financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons GIG chooses to share; and whether you can limit this sharing.

Reasons we can share your nonpublic personal information	Does GIG share?	Can you limit sharing?
For our everyday business purposes — as permitted or required by law, such as to process your transactions, maintain your account(s), conduct research including data analytics, respond to court orders/legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes — to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes — information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes — information about your creditworthiness	Yes	Yes
For nonaffiliates to market to you	No	We don't share
To limit our sharing / Questions?	Call us at (800) 233-1957 and ask for the Privacy Coordinator. Please note: When you are no longer a customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.	

Who we are / Companies to which this notice applies
This notice applies to, and is being provided on behalf of, the following Glatfelter Insurance Group affiliates: Arthur J. Glatfelter Agency, Inc., GIG of Missouri, Inc., Glatfelter Brokerage Services, Glatfelter Claims Management, Inc., Glatfelter Commercial Ambulance, Glatfelter Healthcare Practice, Glatfelter Insurance Services, Glatfelter Program Managers, Glatfelter Public Practice, Glatfelter Religious Practice, Glatfelter Underwriting Services, Inc., The Insurancenter, Susquehanna Agents Alliance, LLC, The Glatfelter Agency, Inc., VFIS, and Volunteer Firemen's Insurance Services, Inc.

What we do	
How does GIG protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include physical, electronic, and procedural safeguards. We require and train our employees to comply with our privacy standards and policies, which are designed to protect customer information.
How does GIG collect my personal information?	We collect your personal information, for example when you: visit our websites, apply for insurance or pay insurance premiums, file an insurance claim or give us your income information, provide employment information. We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only: sharing for affiliates' everyday business purposes – information about your creditworthiness, affiliates from using your information to market to you, sharing for nonaffiliates to market to you. State laws may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. <ul style="list-style-type: none">Our affiliates are companies with which we share common ownership and which offer P&C, life and health, and certain benefit products.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. <ul style="list-style-type: none">GIG does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. <ul style="list-style-type: none">Our joint marketing partners include insurance companies and other companies that provide financial products and services.

Other important information
<p>CA and VT Residents: We will not share your information except for our everyday business purposes, for marketing our products and services to you, as required by law, or with your consent. For VT Residents, we also will not share your credit information to our affiliates without your consent. NV Residents: We are providing this notice to you pursuant to NV state law. To stop marketing calls from us follow the directions in the section "To limit our sharing." NV law requires that we also provide you with the following contact information: Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington Street, Suite 3900, Las Vegas, NV 89101; Phone #: 702-486-3132; email: bcpinfo@ag.state.nv.us.</p> <p>For more information, contact: Glatfelter Insurance Group, Attn: Privacy Coordinator, P.O. Box 2726, York, Pennsylvania 17406, (717) 741-0911, or visit www.glatfelters.com/privacy-policy. This privacy page on our website includes a Google Analytics opt-out link.</p>

HIPAA PRIVACY NOTICE

This HIPAA Privacy Notice is effective as of October 16, 2017.

1. **Statement of Our Duties.** We are committed to protecting the privacy of your protected health information (PHI). PHI is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or health care clearinghouse which is then provided to us and that relates to: (i) your past, present or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present or future payment for the provision of health care to you. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our privacy practices and legal duties. We are required to abide by the terms of this notice.

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE AND MAKE ANY NEW PROVISIONS EFFECTIVE TO ALL OF THE PHI WE MAINTAIN ABOUT YOU. IF WE CHANGE OUR NOTICE, WE WILL POST IT ON OUR WEBSITE AND SEND YOU A COPY IN OUR ANNUAL MAILING, OR YOU MAY OBTAIN A COPY OF THE REVISED NOTICE BY CONTACTING OUR PRIVACY COORDINATOR USING THE INFORMATION IN PARAGRAPH 9.

2. **Statement of Your Rights.** You have a right to know how we may use or disclose your PHI. This notice informs you of those uses and disclosures. There are certain uses and disclosures of your PHI that we are permitted or required to make by law without your permission. For all other uses and disclosures, we first must obtain your permission or written authorization. In addition, you have the following rights:

- The right to request, in writing, that we place additional restrictions on our uses and disclosures of your PHI. However, we are not obligated to agree to impose any such additional restrictions.
- The right to access, inspect and copy the protected information pertaining to you that we maintain in our files about you, and the right to have us correct or amend any information that we create in error. Requests to access or amend your PHI must be made in writing and sent to the contact person and address provided in paragraph 9.
- The right to receive an accounting of the disclosures of your PHI that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations. You must request an accounting in writing by contacting us at the address in paragraph 9. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.
- The right to request, in writing, that you receive communications about your PHI in a confidential manner, for example, by alternative means or an alternative location, such as your work address or work email.
- The right to request an amendment to your PHI if you believe that your PHI is incorrect or incomplete. Your request must be in writing and explain why the PHI should be amended.
- The right to obtain a paper copy of this notice from us on request.

3. **Information We Collect About You.** In order to administer your health benefit programs effectively, we collect the following categories of PHI about you from the following sources:

- PHI that we obtain directly from you, in conversations or on applications or other forms that you fill out.
- PHI that we obtain as a result of our transactions with you.
- PHI that we obtain from your medical records or from medical professionals, which is provided by you or to us with your permission.
- PHI that we obtain from other entities, such as health care providers or other insurance companies, in order to service your policy or carry out other insurance-related needs.

4. **Uses and Disclosures of Protected Information.**

A. ***For Treatment, Payment and Operations.*** In order to administer your health benefit programs effectively, we use and disclose PHI for certain of our activities, including:

- **To Carry Out Treatment Functions.** We may use or disclose your PHI without your permission to enable health care providers to provide you with treatment.
- **To Carry Out Payment Functions.** We may use or disclose your PHI without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing, such as enabling a health care provider to make payment arrangements. Such functions may include reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.
- **To Carry Out Certain Operations Relating To Your Benefit Plan.** We also may use or disclose your PHI without your permission to carry out certain limited activities relating to your health insurance benefits, including reviewing the competence or qualifications of health care professionals, placing contracts for stop-loss insurance and conducting quality assessment activities.
- **To facilitate the underwriting of insurance;** however, we are prohibited from using or disclosing your genetic information for the purpose of underwriting insurance.

B. ***Uses and Disclosures of PHI to Other Entities.*** We also may use and disclose PHI to other covered entities, business associates or other individuals (as permitted by the HIPAA Privacy rule) who assist us in administering your benefit plan and delivering services to its members. In connection with our payment and operations activities, we may contact individuals and other entities ("Business Associates") to perform various functions on our behalf or to provide certain types of services (such as enrollment or member service support). To perform these functions, Business Associates must agree in writing to contract terms designed to appropriately safeguard your PHI.

C. Other Possible Uses and Disclosures of PHI. We may use and disclose your PHI without your written permission for the following purposes:

- To plan sponsors of your group health plan to permit the plan sponsor to perform administrative functions, such as to address member questions, concerns or issue regarding claims, benefits, services, coverage, etc., and summary health information about enrollees in the plan to obtain premium bids for health insurance coverage offered through the group health plan or to modify, amend or terminate your group plan.
- To the extent that federal or state law requires the use or disclosure, such as to Health and Human services upon request for purposes of determining compliance with federal privacy laws, as required by law enforcement officials or pursuant to a court order or subpoena.
- As authorized by and to the extent necessary to comply with workers' compensation or other similar programs that provide benefits for work-related injuries or illnesses.
- As authorized by law and to the extent necessary to service insurance policies and benefits that are exempt benefits, such as in connection with servicing life, disability, property and casualty, accident and sickness, workers' compensation and auto insurance or other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.
- To a public health authority for purposes of public health activities as permitted or required by law.
- To a coroner/medical examiner for purposes of identifying a deceased person, determining cause of death or for such official to perform other duties authorized by law. Also to funeral directors so they may carry out their duties, and to organizations that handle organ, eye or tissue donation or transplantation.
- To a government authority, including a social service or protective services agency, authorized to receive reports of abuse, neglect or domestic violence or to prevent a serious threat to the health or safety of the public.

D. For Any Purposes to Which You Have Not Objected. Unless you object, we may disclose your PHI to a friend or family member that you have identified as being involved in your health care. We also may disclose your PHI to an entity to assist in disaster relief efforts and so that your family can be notified about your condition, status and location. If you are not present or able to agree to these disclosures of your PHI, then we may determine whether the disclosure is in your best interest.

E. As Permitted By Plan Documents. In certain limited circumstances where we may be acting as a third party administrator, we may disclose your PHI to plan sponsors pursuant to the restrictions imposed on the plan sponsor in the sponsor's plan documents.

5. Required Disclosures of Your PHI. We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining compliance with the HIPAA Privacy Rule. We are required to disclose to you most of your PHI that is in a "designated record set" when you request access to this information. We are also required to provide, upon written request, an accounting of any disclosures of PHI that are for reasons other than payment or health benefits operations.

6. Other Uses and Disclosures of Your PHI. Sometimes we are required to obtain written authorization for use and disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. §164.508(a) are: (i) for marketing purposes; (ii) if we intend to sell your PHI; or (iii) for psychotherapy notes. We do not and will not sell or share your PHI with any non-affiliated third party for any purpose unless you authorize it or it is otherwise permitted by law. Other uses and disclosures of your PHI that are not described above will be made only with your written, permission, and any permission that you give us may be revoked by you at any time. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

7. Questions and Complaints About Use of PHI. If you want more information about our privacy policies or practices or have any questions or concerns, please contact us using the information in paragraph 9. You may submit a written complaint either directly to us or to the U.S. Department of Health and Human Services (HHS) if you believe that your rights with respect to our protection of your PHI have been violated. We will provide you with the address to file your complaint with HHS upon request. To file a complaint with us, you may submit a complaint in writing that includes as many details (such as names and dates) as possible to our Privacy Officer at the address in Paragraph 9. We support your right to protect the privacy of your PHI. You will not be retaliated against in any way for filing a complaint.

8. Our Practices Regarding Confidentiality and Security. We restrict access to PHI about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your PHI. We do not engaged in fundraising activities using PHI, however, if we did engage in such activity, then you would have the opportunity to opt out of receiving fundraising communications. Subject to applicable regulatory reporting requirements, exceptions and safe harbors, we will notify affected individuals following a breach of their unsecured PHI.

9. Contact Person For Filing Complaint or Obtaining Further Information:

GLATFELTER INSURANCE GROUP
ATTN: PRIVACY COORDINATOR
183 Leader Heights Road, P.O. Box 2726, York, PA 17405
(717) 741-0911
www.glatfelters.com/privacy-policy

Our Policy Regarding Dispute Resolution. Any controversy or claim arising out of or relating to our privacy policy, or the breach thereof, shall be settled by arbitration in accordance with the rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

FACTS

Why?

What?

How?

WHAT DOES AMERICAN INTERNATIONAL GROUP, INC. (AIG) DO WITH YOUR PERSONAL INFORMATION?

Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and Medical Information
- Income and Credit History
- Payment History and Employment Information

When you are *no longer* our customer, we continue to share your information as described in this notice.

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons AIG chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does AIG share?	Can you limit this sharing?
For our everyday business purposes — such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, conduct research including data analytics, or report to credit bureaus	Yes	No
For our marketing purposes — to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes — information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes — information about your creditworthiness	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?

For AIG Insurance Companies: Call 866-244-4786; Fax: 212-458-7081 or E-Mail: CIPrivacy@aig.com

For Pet insurance sold by AIG Insurance Companies: Call 866-937-7387 or E-Mail: CIPrivacy@aig.com

For LiveTravel, Inc., Travel Guard Group, Inc. or AIG Travel Assist, Inc.: Call 866-244-4786 or E-Mail: CIPrivacy@aig.com

Who we are

Who is providing this notice? The insurance company subsidiaries of American International Group, Inc. (AIG) underwriting property-casualty, accident & health, life insurance and related services and certain marketing subsidiaries of AIG listed below.

What we do

How does AIG protect my personal information? To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We restrict access to employees, representatives, agents, or selected third parties who have been trained to handle nonpublic personal information.

How does AIG collect my personal information? We collect your personal information, for example, when you

- apply for insurance or pay insurance premiums
- file an insurance claim or give us your income information
- provide employment information

We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.

Why can't I limit all sharing? Federal law gives you the right to limit only

- sharing for affiliates' everyday business purposes— information about your creditworthiness
- affiliates from using your information to market to you
- sharing for nonaffiliates to market to you

State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions

Affiliates Companies related by common ownership or control. They can be financial and nonfinancial companies.

- *Our affiliates include the member companies of American International Group, Inc.*

Nonaffiliates Companies not related by common ownership or control. They can be financial and nonfinancial companies.

- *AIG does not share with nonaffiliates so they can market to you.*

Joint marketing A formal agreement between nonaffiliated financial companies that together market financial products or services to you.

- *Our joint marketing partners include companies with which we jointly offer insurance products, such as a bank.*

Other important information

This notice is provided by American Home Assurance Company; AIG Assurance Company; AIG Property Casualty Company; AIG Specialty Insurance Company; Commerce and Industry Insurance Company; Granite State Insurance Company; Illinois National Insurance Co.; Lexington Insurance Company; AIU Insurance Company; National Union Fire Insurance Company of Pittsburgh, Pa.; National Union Fire Insurance Company of Vermont; New Hampshire Insurance Company; The Insurance Company of the State of Pennsylvania; (collectively the "AIG Insurance Companies"). This notice is also provided by certain marketing subsidiaries of AIG, including Morefar Marketing, Inc., LLC, Travel Guard Group, Inc., AIG Travel Assist, Inc. and LiveTravel, Inc. who market insurance or non-insurance products and services to consumers.

For Vermont Residents only. We will not disclose information about your creditworthiness to our affiliates and will not disclose your personal information, financial information, credit report, or health information to nonaffiliated third parties to market to you, other than as permitted by Vermont law, unless you authorize us to make those disclosures. Additional information concerning our privacy policies can be found using the contact information above for Questions.

For California Residents only. We will not share information we collect about you with nonaffiliated third parties, except as permitted by California law, such as to process your transactions or to maintain your account.

For Nevada Residents Only. We are providing this notice pursuant to Nevada state law. You may elect to be placed on our internal Do Not Call list by contacting us as listed above. Nevada law requires that we also provide you with the following contact information: Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington Street, Suite 3900, Las Vegas, NV 89101; Phone number: 702-486-3132; email: aginfo@ag.nv.gov. You may contact the applicable customer service department using the contact information above or by writing to us at Privacy Officer, 175 Water Street, 18th Floor, New York, NY 10038.

You have the right to see and, if necessary, correct personal data. This requires a written request, both to see your personal data and to request correction. We do not have to change our records if we do not agree with your correction, but we will place your statement in our file. If you would like a more detailed description of our information practices and your rights, please write to us at: Privacy Officer, 175 Water Street, 18th Floor, New York, NY 10038.

NOTICE OF AVAILABILITY OF HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS PROVIDED TO YOU FOR INFORMATIONAL PURPOSES ONLY. YOU ARE NOT REQUIRED TO CALL OR TAKE ANY ACTION IN RESPONSE TO THIS NOTICE.

The Notice applies to the insurance products that provide payment for the cost of medical care as issued by the following companies (the “Company”):

American General Life Insurance Company¹
The United States Life Insurance Company in the City of New York
National Union Fire Insurance Company of Pittsburgh, Pa.

In accordance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule, we are required to notify you of the availability of our HIPAA Notice of Privacy Practices.

If you would like to receive a paper copy of the HIPAA Notice of Privacy Practices, please contact us at:

<i>HIPAA Privacy Officer</i> 2919 Allen Parkway L3-20 Houston, TX 77019 hipaaquestions@aig.com	
Phone Numbers:	
American General Life Insurance Company (AGL) and The United States Life Insurance Company in the City of New York (US Life)	1-800-231-3655
AIG Financial Network	1-800-888-2452
AIG’s Group Benefits	1-800-346-7692 please follow prompt for claims
Long Term Care	1-888-565-3769
National Union Fire Insurance Company of Pittsburgh, Pa.	1-866-244-4786

¹ This Company does not solicit business in New York.

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038

(212) 458-5000

(a capital stock company, herein referred to as the Company)

SCHEDULE OF COVERAGE - VOLUNTEER

Policy Number: VFP-4347-4905E-4

Policyholder: APPALACHIAN SEARCH AND RESCUE CONFERENCE, INC
(Name and Address) PO BOX 400440
CHARLOTTESVILLE, VA 22904-0000

Policy Effective Date: 2/1/2020 Term: 1 Year

Policy Termination Date: 2/1/2021 Premium: \$2,347

This Schedule of Coverage provides only those benefits that have a specified amount entered opposite the name of the benefit. Benefits that are followed by the word "none" are not provided under this policy.

PART COVERAGE

I. Loss of Life Benefits

A. Accidental Death Benefits	
(1) Accidental Death Benefit Amount	\$10,000
(2) Seat Belt Benefit Amount	\$5,000
(3) Safety Vest Benefit Amount.....	\$5,000
(4) Military Death Benefit Amount	\$15,000
B. Illness Loss of Life Benefit Amount	\$10,000
C. Dependent Child and Education Benefit Amount.....	\$30,000
D. Spousal Support and Education Benefit Amount	\$15,000
E. Memorial Benefit Amount.....	\$5,000
F. Dependent Elder Benefit Amount.....	\$5,000
G. Repatriation Benefit Amount.....	\$2,500

II. Lump Sum Living Benefits

A. Accidental Dismemberment and Paralysis Benefit Principal Sum	\$10,000
B. Vision Impairment Benefit Principal Sum	\$10,000
C. Injury Permanent Impairment Benefit Principal Sum	\$10,000
D. Heart Permanent Impairment Benefit Principal Sum	\$10,000
E. Illness Permanent Impairment Benefit Principal Sum.....	\$10,000
F. Cosmetic Disfigurement Resulting From Burns Benefit Principal Sum.....	\$10,000
G. HIV Positive Lump Sum Living Benefit Principal Sum	\$10,000

- III. Weekly Income Benefits**
- A. Total Disability Benefits
- (1) Total Disability Weekly Amount (first 28 days) \$100
- (2) Total Disability Maximum Weekly Amount (after 28 days) \$100
- (3) Total Disability Minimum Weekly Amount \$25
- B. Partial Disability Benefits
- (1) Partial Disability Weekly Amount (first 28 days) \$50
- (2) Partial Disability Maximum Weekly Amount (after 28 days) \$50
- (3) Partial Disability Minimum Weekly Amount \$13
- C. Disability Benefits General
- IV. Occupational Retraining Benefit Maximum Amount \$20,000**
- V. Weekly Injury Permanent Impairment Benefit ☒ Yes ☐ No**
- VI. Medical Expense Benefits**
- A. Medical Expense Benefit Maximum Amount \$10,000
- Medical Expense Benefit Options
- (1) Excess of Workers' Compensation or No-Fault Auto Insurance Benefits ☐
- (2) Primary Medical Expense Benefit ☒
- B. Cosmetic Plastic Surgery Maximum Amount \$25,000
- C. Post-Traumatic Stress Disorder Maximum Amount \$25,000
- D. Critical Incident Stress Management Maximum Amount \$25,000
- E. Family Expense Benefit Amount (per day) \$100
- F. Family Bereavement and Trauma Counseling Benefit Amount (per person) \$1,000
- VII. Transition Benefit ☒ Yes ☐ No**
- VIII. Felonious Assault Benefit Amount \$25,000**
- IX. Home Alteration and Vehicle Modification Benefit Maximum Amount \$50,000**
- X. Optional Benefits**
- A. Weekly Hospital Benefit Amount NONE
- B. First Week Total Disability Benefit Amount NONE
- C. Coordinated 28 Day Total Disability Benefit Amount NONE
- D. Extended Total Disability Benefit ☐ Yes ☒ No
- E. Long-Term Total Disability Benefit ☐ Yes ☒ No
- F. Cost Of Living Adjustment (COLA) Benefits
- (1) Weekly Injury Permanent Impairment COLA ☐ Yes ☒ No
- (2) Long-Term Total Disability COLA ☐ Yes ☒ No
- G. Extra Expense Benefit
- Extra Expense Benefit Monthly Amount \$500
- Extra Expense Benefit Maximum Amount \$12,000
- H. 24-Hour Accident Benefit Amount NONE
- I. Off-Duty Accident Benefit Amount NONE

SCHEDULE OF FORMS AND RIDERS

POLICY FORMS ATTACHED AT ISSUANCE:

V50000NUFIC	Schedule of Coverage - Volunteer
V50004NUFIC	Blanket Accident and Sickness Insurance Policy – Volunteer Members
V50018NUFIC-VA	Virginia Residents Rider
V50036NUFIC	Mandatory Quarantine Rider
GA-VA	VA Life and Health Insurance Guaranty Assoc Notice
VA Notice	Important Information Regarding Your Insurance
89644 (06/13)	Economic Sanctions Endorsement
OFAC Notice	Office of Foreign Assets Control Notice

SCHEDULE OF POLICYHOLDERS/PARTICIPATING ORGANIZATIONS

ADDITIONAL ENTITIES:

ALLEGHENY MOUNTAIN RESCUE GROUP
BLUE RIDGE MOUNTAIN RESCUE GROUP
MARYLAND SEARCH & RESCUE GROUP
MOUNTAINEER AREA RESCUE GROUP
NORTHWEST PENNSYLVANIA K-9 SEARCH AND RESCUE
SEARCH AND RESCUE OHIO
SHENANDOAH MOUNTAIN RESCUE GROUP

PAYMENT/INSTALLMENT SCHEDULE

THE TOTAL POLICY PREMIUM FOR THIS POLICY IS \$2,347, PAYABLE IN INSTALLMENTS AS FOLLOWS:

2/1/2020	\$1,174
8/1/2020	\$1,173

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038

(212) 458-5000

(a capital stock company, herein referred to as the Company)

NOTICE

This is not comprehensive health insurance coverage. It does not satisfy the requirements of minimum essential coverage under the Affordable Care Act.

BLANKET ACCIDENT AND SICKNESS INSURANCE POLICY VOLUNTEER MEMBERS

This policy is a legal contract between the **Policyholder** and/or **Participating Organization** named in the application and **Us**. **We** agree to insure certain persons (herein called **Insured Persons**) against loss covered by this policy subject to its provisions, benefits, limitations and exclusions. The persons eligible to be insured are all persons described in this policy as **Insured Persons**. This policy provides accident and sickness insurance to **Insured Persons** while they are participating in a **Covered Activity**.

CONSIDERATION – TERM

This policy is issued in consideration of the payment of the required premium when due as shown in the **Schedule**. **We** agree to provide the benefits shown in the **Schedule** to **Insured Persons** in accordance with the provisions and conditions of this policy. This policy may be changed or terminated without consent of or notice to each **Insured Person**.

The term of this policy begins on the policy Effective Date and continues in effect until the policy Termination Date, both of which are shown in the **Schedule**, as long as premiums are paid when due, unless otherwise terminated as further provided in this policy. If this policy is terminated, insurance ends on the date to which premiums have been paid. All periods of insurance will begin and end at 12:01 AM Standard Time at the address of the **Policyholder** and/or **Participating Organization**.

RENEWAL

After the policy Termination Date shown in the **Schedule**, this policy may be renewed for additional periods of time by mutual written consent of **Us** and the **Policyholder** and/or **Participating Organization** at the premium rates set by **Us** for the renewal period. If this policy is not renewed, insurance will stop on the date to which premiums have been paid subject to the Grace Period provision.

POLICY EFFECTIVE AND TERMINATION DATES

Effective Date. This policy begins on the policy Effective Date shown in the **Schedule** at 12:01 AM Standard Time at the address of the **Policyholder** and/or **Participating Organization** where this policy is delivered.

Termination Date. **We** may terminate this policy by giving 30 days advance notice in writing to the **Policyholder** and/or **Participating Organization**. This policy may, at any time, be terminated by mutual written consent of **Us** and the **Policyholder** and/or **Participating Organization**. Termination takes effect at 12:01 AM at the **Policyholder** and/or **Participating Organization's** address on the date of termination.

INDIVIDUAL EFFECTIVE AND TERMINATION DATES

Coverage for an **Insured Person** will take effect on the later of: (1) the policy **Effective Date** shown in the **Schedule**; or (2) the date he or she becomes an **Insured Person** as defined in this policy.

Coverage for an **Insured Person** will end on the earliest of: (1) the date this policy terminates; (2) the date he or she is no longer an **Insured Person** as defined in this policy; or (3) the date the **Policyholder** and/or **Participating Organization's** coverage ends.

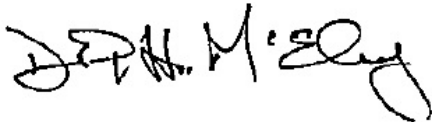
Termination of coverage will not affect any loss resulting from participation in a **Covered Activity** when such participation occurred prior to the date of termination.

PREMIUM

Premiums. Premiums are payable to **Us** at the rates described in the Premium section of the **Schedule**. **We** may change the required premiums as a condition of any renewal of this policy. **We** may also change the required premiums at any time when any change in coverage affecting premiums is made in this policy.

This policy is governed by the laws of the state in which it is delivered.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this policy:



President



Secretary

PLEASE READ THIS POLICY CAREFULLY.

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DEFINITIONS

(Additional defined terms can be found throughout this policy)

Any term in capitals and quotations or any term in bold type in the policy, application, riders, endorsements, amendments or other attached papers are to be given the meanings as ascribed in this section or as later defined.

Administrative Personnel – means a person who works an average of 25 hours or more per week while acting within the scope of his or her employment for the **Policyholder** and/or **Participating Organization**, which does not include any emergency response or any emergency response training as listed in items (1), (2), (3) or (4) under **Covered Activities**.

Average Weekly Wage – means an average weekly wage determined by the greater of:

- (1) the weekly average of the total of wages, salaries, tips, or unemployment compensation for the calendar year immediately preceding the year in which the loss occurred;
- (2) the weekly average of wages earned in the 12 months preceding the loss;
- (3) the weekly average of the annualized weekly wage earned in the three months preceding the loss; or
- (4) for the self-employed, the weekly average of the amount taken from Schedule C, E, or F which is reported on IRS Form 1040 as net taxable income, excluding rental, investment or passive income.

The **Average Weekly Wage** will be verified by the **Insured Person's** employer and/or tax records.

Consumer Price Index – means the consumer price index published by the United States Department of Labor's Bureau of Labor Statistics for All Urban Consumers, All Items (CPI-U).

Covered Activity – means any activity, including travel directly to and from such activity, which is a normal duty of an **Insured Person**, including any:

- (1) emergency response for fire suppression and rescue or emergency medical activity;
- (2) training exercise which simulates an emergency and where active physical participation is required;
- (3) **Firematic Events or Contests**;
- (4) class room training;
- (5) fund-raising activities including athletic activities solely for the purpose of raising funds for the **Policyholder** and/or **Participating Organization** or other non-profit organization when such fund-raising is performed as an activity of the **Policyholder** and/or **Participating Organization**, except any form of football, hockey, lacrosse, soccer, boxing, rugby or martial arts;
- (6) official functions attended primarily by members of the **Policyholder** and/or **Participating Organization** for which the purpose is to further the business of the **Policyholder** and/or **Participating Organization** (i.e. installation dinners, banquets, etc.);
- (7) official conventions, conferences or meetings of emergency fire, rescue or medical personnel attended by the **Insured Person** on behalf of the **Policyholder** and/or **Participating Organization** including personal travel and activities related to attending such convention, conference or meeting;
- (8) participation in pre-approved covered athletic events or programs conducted on the premises of the **Policyholder** and/or **Participating Organization**;
- (9) authorized public safety education events; and
- (10) administrative or maintenance duties.

Under no circumstance is there coverage for participation in the athletic events listed in Exclusion number 9.

The **Covered Activity** must be performed at the direction, or with the knowledge, of an officer of the **Policyholder** and/or **Participating Organization**, unless immediate action is required of the **Insured Person** at the scene of an emergency not on behalf of the **Policyholder** and/or **Participating Organization** or any other organization.

Covered Person - means all members who are listed on the **Policyholder** and/or **Participating Organization's** roster. The roster will be maintained and periodically updated by the **Policyholder** and/or **Participating Organization**. The roster will be kept on file by the **Policyholder** and/or **Participating Organization**.

Dependent Child - means any unmarried child of the **Insured Person** who was dependent upon the **Insured Person** and either claimed on the **Insured Person's** most recent or final federal tax return, or was dependent as a result of a legally enforceable agreement filed with a court or other administrative body.

Firematic Events or Contests – means practice or participation in an organized event intended to enhance the **Insured Person's** skills or emergency reaction times. These events include, but are not limited to, departmental or interdepartmental:

- (1) apparatus pumping contests;
- (2) battle of the barrel;
- (3) antique pumping;
- (4) hose rolling contests;
- (5) equipment donning contests;
- (6) bucket brigades;
- (7) ladder climbs;
- (8) tug of war contests; and
- (9) apparatus operation rodeos.

Gainful Occupation – means a job for which an **Insured Person** is qualified by reason of education, training or experience, that has a reasonable expectation to provide more than 85% of pre-disability earnings.

Hemiplegia - means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.

HIV - means human immunodeficiency virus.

Hospital - means a facility which:

- (1) is operated according to law for the care and treatment of injured and sick people;
- (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
- (3) has 24 hour nursing service by registered nurses (R.N.'s); and
- (4) is supervised by one or more **Physicians**.

A **Hospital** does not include:

- (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; or
- (2) a facility which is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes.

Illness(es) – means any disease, sickness, or infection of an **Insured Person** while coverage under this policy is in force as to the **Insured Person**. The **Illness** must:

- (1) manifest itself during a specific **Covered Activity** with the result that the **Insured Person** interrupts his or her participation in such **Covered Activity** in order to receive immediate **Medical Treatment**; or
- (2) directly result from participation in a **Covered Activity** and also result in the **Insured Person** receiving **Medical Treatment** within 48 hours of participation in such **Covered Activity**. The requirement that **Medical Treatment** be received within 48 hours is waived for **Infectious Diseases**.

Immediate Family Member – means the **Insured Person's** spouse, child, parent, brother or sister.

Infectious Disease(s) – means an easily transmitted, potentially life-threatening disease resulting from bacterial, viral, fungal, or protozoan infection.

Injury(ies) – means accidental bodily injury sustained by the **Insured Person**:

- (1) during and resulting from an **Insured Person's** participation in a specific **Covered Activity** while coverage under this policy is in force as to the **Insured Person**;
- (2) which directly (independent of sickness, disease, mental incapacity or any other cause) causes a loss to the **Insured Person**; and
- (3) which is not otherwise defined as an **Illness**.

The term **Injury**, for the purposes of this policy, will not include human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), or any heart or circulatory malfunction.

Insured Person(s) – means any officially designated member of the **Policyholder** and/or **Participating Organization** while acting as:

- (1) a volunteer member for the **Policyholder** and/or **Participating Organization**;
- (2) any junior member or member in training;
- (3) any commissioner, director, trustee or other similar position associated with the **Policyholder** and/or **Participating Organization**;
- (4) any bystander deputized at the time of the emergency by an official of the **Policyholder** and/or **Participating Organization** to assist in an emergency, but only during the actual emergency;
- (5) any auxiliary member;
- (6) any non-member who is requested to participate by the auxiliary or **Policyholder** and/or **Participating Organization**;
- (7) any member who receives remuneration for on-call duty or out of pocket expenses and
- (8) **Administrative Personnel**;

Subject to the following:

An **Insured Person** will not include a **Paid Employee** while acting within the scope of his or her employment unless the policy is specifically endorsed to provide coverage for career members, except for **Administrative Personnel**.

Limb(s) - means entire arm or entire leg.

Long-Term Total Disability - means:

- (1) For an **Insured Person** with an occupation producing wages as described in the definition of **Average Weekly Wage** at the time **Total Disability** benefits become payable, **Long-Term Total Disability** means the inability to perform all of the material and substantial duties of any **Gainful Occupation**.
- (2) For an **Insured Person** who does not have an occupation producing wages as described in the definition of **Average Weekly Wage** at the time **Total Disability** benefits become payable, **Long-Term Total Disability** means:
 - (a) the inability to perform all of the material and substantial duties of an occupation for which the **Insured Person** is qualified by reason of education, training, or experience; or
 - (b) the inability to perform any two of six activities of daily living of the **Insured Person**. Activities of daily living include mobility, eating, elimination, cognition, personal hygiene, and dressing.

The **Insured Person** must be under the regular care of a **Physician** during **Long-Term Total Disability**.

Medical Treatment - means treatment by a **Physician** or at a **Hospital** for the **Illness**.

Other Valid and Collectible Insurance – means any:

- (1) group plan, program, or insurance policy;
- (2) other group hospital, surgical or medical benefit plan;
- (3) union welfare plans or group employer or employee benefit programs;
- (4) no-fault automobile insurance plan or similar law; or
- (5) regular or disability benefits paid under a **Retirement Program** after the commencement of **Partial Disability** or **Total Disability** benefits under this policy.

Other Valid and Collectible Insurance will not include benefits provided by the United States Social Security Act or any individual disability insurance plans.

Out-Patient Physical Therapy – means rehabilitative physical therapy which is:

- (1) received without being confined overnight in a **Hospital** as a registered bed patient;
- (2) an approved therapy program;
- (3) necessary for the rehabilitation of an **Insured Person** from an **Injury** or an **Illness** for which he or she was confined in a **Hospital** for treatment;
- (4) administered by a licensed physical therapist; and
- (5) monitored by a **Physician**.

Paid Employee(s) – means a person who receives compensation and works an average of 25 hours or more per week for the **Policyholder** and/or **Participating Organization**. The time frame used to determine the average hours or the salaried schedule will be the same time frame used to calculate the **Average Weekly Wage**. **Paid Employee** does not include **Administrative Personnel**.

Paraplegia - means the complete and irreversible paralysis of both lower **Limbs**.

Partial Disability, Partially Disabled – means,

- (1) For an **Insured Person** with an occupation producing wages as described in the definition of **Average Weekly Wage**, the inability to perform one or more, but not all, of the material and substantial duties of his or her own occupation.
- (2) If the **Insured Person** does not have an occupation producing wages as described in the definition of **Average Weekly Wage, Partial Disability, Partially Disabled** means:
 - (a) the inability to perform one or more, but not all, of the material and substantial duties of an occupation for which the **Insured Person** is qualified by reason of education, training, or experience; or
 - (b) the inability to perform one or more, but not all, of the regular activities of the **Insured Person** prior to the covered **Injury or Illness**.

The **Insured Person** must be under the regular care of a **Physician** during **Partial Disability**.

Participating Organization(s) – means a non-profit emergency service organization, municipality or political subdivision that elects coverage under this policy and pays the required premium. The **Participating Organization** is named in the **Schedule** and/or the Schedule of Policyholders/Participating Organizations. Coverage for such **Participating Organization** will be in force at 12:01 A.M. on the policy Effective Date shown in the **Schedule** subject to payment of the required premium. Coverage is limited to **Insured Persons** of any fire, emergency, rescue, or ambulance department of the municipality or political subdivision.

Permanent Impairment - means a medical condition which is a physical or functional abnormality or loss, which remains after the maximum medical rehabilitation has been achieved, and which is considered stable or non-progressive by the **Physician** at the time an evaluation is made.

Physician(s) – means any duly licensed medical practitioner:

- (1) who is acting within the scope of his or her license; and
- (2) who is not the **Insured Person** or an **Immediate Family Member**.

Policyholder – means a non-profit emergency service organization, municipality or political subdivision that elects coverage under this policy and pays the required premium. The **Policyholder** is named in the **Schedule**. Coverage for such **Policyholder** will be in force at 12:01 A.M. on the policy Effective Date shown in the **Schedule** subject to payment of the required premium. Coverage is limited to **Insured Persons** of any fire, emergency, rescue, or ambulance department of the municipality or political subdivision.

Post-Traumatic Stress Disorder – means emotional distress resulting from a **Traumatic Incident** experienced by an **Insured Person** which adversely affects the psychological and physical well-being of the **Insured Person**.

Quadriplegia - means the complete and irreversible paralysis of both upper and both lower **Limbs**.

Reasonable and Customary Expense – means an expense which:

- (1) is charged for treatment, supplies or medical services medically necessary to treat the **Insured Person's** condition;
- (2) does not exceed the usual level of charges for similar treatment, supplies or medical services in the locality where the expense is incurred; and
- (3) does not include charges that would not have been made if no insurance existed.

Retirement Program - means any normal, early, or disability retirement benefit, provided by the **Policyholder** and/or **Participating Organization**, State, Union or other entity where eligibility and/or benefits are based on employment with the **Policyholder** and/or **Participating Organization**.

Schedule – means the Schedule of Coverage which is attached to this policy.

Total Disability, Totally Disabled – means,

- (1) For an **Insured Person** with an occupation producing wages as described in the definition of **Average Weekly Wage**, the inability to perform all of the material and substantial duties of his or her own occupation.
- (2) If the **Insured Person** does not have an occupation producing wages as described in the definition of **Average Weekly Wage**, **Total Disability, Totally Disabled** means:
 - (a) the inability to perform all of the material and substantial duties of an occupation for which the **Insured Person** is qualified by reason of education, training, or experience; or
 - (b) the inability to perform all of the regular activities of the **Insured Person** prior to the covered **Injury** or **Illness**.

The **Insured Person** must be under the regular care of a **Physician** during **Total Disability**.

Traumatic Incident – means an abnormal experience, outside the range of usual human experiences and includes, but is not limited to:

- (1) line-of-duty death or serious injury to other **Insured Persons**;
- (2) a single incident having multiple casualties;
- (3) death or serious injury of a child; and
- (4) dealing with victims known to the **Insured Person**.

Uniplegia - means the complete and irreversible paralysis of one **Limb**.

We, Us, or Our refers to National Union Fire Insurance Company of Pittsburgh, Pa.

PART I. LOSS OF LIFE BENEFITS

A. ACCIDENTAL DEATH BENEFITS

- (1) Accidental Death Benefit. **We** will pay the Accidental Death Benefit Amount shown in the **Schedule** if **Injury** to an **Insured Person** results in the **Insured Person's** death.

In the event that an Accidental Death Benefit and an Accidental Dismemberment Benefit and/or a Vision Impairment Benefit are payable under this policy as a result of any **Injury** sustained while participating in the same **Covered Activity**, only one benefit, the largest, will be paid.

- (2) Seat Belt Benefit. If an Accidental Death Benefit is payable under this policy and the accident which caused the **Insured Person's** accidental death occurred while the **Insured Person** was wearing a properly fastened automotive seat belt or other vehicle occupant restraint, such as an ambulance harness or tether, **We** will pay an additional amount equal to the Seat Belt Benefit Amount shown in the **Schedule**.
- (3) Safety Vest Benefit. If an Accidental Death Benefit is payable under this policy and death results from being struck as a pedestrian while on the scene of a motor vehicle accident or while directing traffic and the **Insured Person** was wearing an approved American National Standards Institute, Inc. (ANSI)/ Manual on Uniform Traffic Control Devices (MUTCD) "Safety Vest", **We** will pay an additional amount equal to the Safety Vest Benefit Amount shown in the **Schedule**.

"**Safety Vest**" - means a vest approved in the MUTCD as published by the ANSI.

- (4) Military Death Benefit. If bodily injury sustained while serving or training on behalf of the United States Military or respective Guard or Reserve Unit results in a **Covered Person's** death, **We** will pay the Military Death Benefit shown in the **Schedule**. Death must occur within 12 months of the bodily injury. Exclusions 4 and 8 do not apply to this benefit.

No Military Death Benefit is payable if an Accidental Death Benefit is payable under this policy.

B. ILLNESS LOSS OF LIFE BENEFIT

If death to an **Insured Person**:

- (1) occurs during a specific **Covered Activity** and is not otherwise payable as an Accidental Death Benefit; or
- (2) occurs due to a covered **Illness** as a result of participation in a specific **Covered Activity** or
- (3) occurs due to a heart attack or stroke within 48 hours of participating in:
- (a) an emergency response for fire suppression and rescue or emergency medical activity; or
 - (b) a training exercise which simulates an emergency and where active physical participation is required,

We will pay the Illness Loss of Life Benefit shown in the **Schedule**.

Either death or **Medical Treatment** for the **Illness** must occur within 48 hours of the **Covered Activity**. The requirement that death or **Medical Treatment** for the **Illness** be within 48 hours is waived for **Infectious Disease**.

No Illness Loss of Life Benefit will be payable if an Accidental Death Benefit is payable under the policy, or if, as a direct result of participation in the same **Covered Activity**, an HIV Positive Benefit was paid to the **Insured Person** under this policy.

C. DEPENDENT CHILD AND EDUCATION BENEFIT

If either an Accidental Death Benefit or an Illness Loss of Life Benefit is payable under the policy, **We** will pay the Dependent Child and Education Benefit Amount shown in the **Schedule** for each **Dependent Child**. **We** may make payment directly to the **Dependent Child's**:

- (1) guardian; or
- (2) to an individual or institution with custody of the **Dependent Child** if;
 - (a) the **Dependent Child** is a minor or is not competent to give a valid receipt for payment due him or her; and
 - (b) no request for payment has been received by **Us** from a duly appointed guardian or other legally appointed representative.

Payment made in this manner will release **Us** from all liability to the extent of any payment made.

D. SPOUSAL SUPPORT AND EDUCATION BENEFIT

If either an Accidental Death Benefit or an Illness Loss of Life Benefit is payable under the policy, **We** will pay the Spousal Support and Education Benefit Amount shown in the **Schedule** to the **Insured Person's** surviving spouse. In no event will more than one Spousal Support and Education Benefit Amount be paid.

E. MEMORIAL BENEFIT

If either an Accidental Death Benefit or an Illness Loss of Life Benefit is payable under the policy for each such death, **We** will also pay the Memorial Benefit Amount shown in the **Schedule** to the **Policyholder** and/or **Participating Organization**.

F. DEPENDENT ELDER BENEFIT

If either an Accidental Death Benefit or an Illness Loss of Life Benefit is payable under the policy, **We** will pay the Dependent Elder Benefit Amount shown in the **Schedule** for each "Dependent Elder". **We** may make payment directly to the "Dependent Elder". Payment made in this manner will release **Us** from all liability to the extent of any payment made.

"**Dependent Elder**" - means any parent, parent-in-law, grandparent, grandparent-in-law, great grandparent or great grandparent-in-law of the **Insured Person** who was dependent upon the **Insured Person** and claimed on the **Insured Person's** final federal tax return.

G. REPATRIATION BENEFIT

If an Accidental Death Benefit or Illness Loss of Life Benefit is payable under this policy and the **Insured Person** was beyond a 30 mile radius from his or her current place of primary residence at the time of death, **We** will pay for reasonable expenses incurred to transport his or her body to the local vicinity of their current place of primary residence.

We will not pay more than the Repatriation Benefit Amount shown in the **Schedule** per **Insured Person**.

PART II. LUMP SUM LIVING BENEFITS

A. ACCIDENTAL DISMEMBERMENT AND PARALYSIS BENEFIT

If **Injury** to an **Insured Person** results in a “Loss” listed below, **We** will pay the indicated percentage of the Accidental Dismemberment and Paralysis Principal Sum shown in the **Schedule** for the “Loss” suffered. If the **Insured Person** suffers more than one “Loss” as a result of any one **Injury**, only one amount, the largest, will be paid.

Accidental Dismemberment and Paralysis Chart

<u>For Loss of:</u>	<u>% of Principal Sum Payable</u>
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Uniplegia	100%
Both Hands or Both Feet	100%
One Hand and One Foot.....	100%
Entire Sight of Both Eyes	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye.....	100%
Speech and/or Hearing	100%
One Arm or One Leg	100%
One Hand or One Foot	50%
Entire Sight of One Eye	50%
Both Thumbs	50%
One Thumb.....	25%
Each Joint of a Finger or Toe	10%

“**Loss**” - means **Quadriplegia**, **Paraplegia**, **Hemiplegia**, **Uniplegia**, or with reference to the foot, a complete severance through or above the ankle joint; with reference to the hand, the complete severance of the distal, proximal or medial phalanx of four fingers; with reference to the arm or leg, the complete severance through or above the elbow or knee joint; with reference to the thumb, the complete severance at the metacarpophalangeal joint; and with reference to a joint of a finger or toe, the complete severance of a distal, proximal or (where applicable) medial phalanx. “**Loss**” of speech or hearing means the total and irrecoverable loss of speech and/or hearing. “**Loss**” of sight means the total and irrecoverable loss of sight.

In the event that an Accidental Dismemberment Benefit and an Accidental Death Indemnity Benefit are payable under this policy as a result of any **Injury** sustained while participating in the same **Covered Activity**, only one benefit, the largest, will be paid.

B. VISION IMPAIRMENT BENEFIT

If **Injury** to an **Insured Person** results in “Permanent Damage” to the **Insured Person’s** eyesight, **We** will pay the indicated percentage of the Vision Impairment Benefit Principal Sum shown in the **Schedule**, for each impaired eye, based on the degree of vision impairment according to the Vision Impairment Chart shown below. This benefit chart will apply separately to each eye.

Vision Impairment Chart

<u>Vision Impairment</u>	<u>% of Vision Impairment Benefit Payable Per Each Eye</u>
20/20	0.00%
20/30	2.75%
20/40	5.50%
20/50	8.25%
20/60	11.00%
20/80	16.50%
20/100	22.00%
20/120	28.00%
20/150	36.00%
20/180	44.50%
20/200 or poorer	50.00%

If the sight of an eye is less than 20/20 before the "Permanent Damage", **We** will pay a benefit based only upon the additional impairment due to the **Injury**. In no event will **We** pay both an Accidental Dismemberment and Paralysis Benefit for a loss of sight and a Vision Impairment Benefit for **Injury** to the same eye sustained while participating in the same **Covered Activity**.

If a Vision Impairment Benefit is payable, it will be in addition to any Accidental Dismemberment and Paralysis Benefit payable for any non-vision related **Injury** sustained while participating in the same **Covered Activity**. However, in no event will the total amount of benefits payable as a result of any one **Injury** exceed 100% of the largest Principal Sum shown in the **Schedule** for these benefits.

"**Permanent Damage**" - means with reference to the eyes, irreparable **Injury** which results in permanently impaired vision, but not in total and irrecoverable loss of sight.

C. INJURY PERMANENT IMPAIRMENT BENEFIT

If an **Insured Person** suffers a **Permanent Impairment** due to an **Injury** and the **Insured Person** participates in an approved physical rehabilitation program if his or her physical condition so warrants, **We** will pay the impairment rating percentage of the Injury Permanent Impairment Benefit Principal Sum shown in the **Schedule**. In no event will an Injury Permanent Impairment Benefit be payable if the Heart Permanent Impairment Benefit or an Illness Permanent Impairment Benefit is payable for any one **Injury** or **Illness** sustained while participating in the same **Covered Activity**.

To Determine the Benefit Payable

The **Insured Person's Permanent Impairment**, due to an **Injury**, will be assigned an impairment value by an examining **Physician**. This value will be expressed as a percentage in relation to the whole person. The impairment rating will be determined by the most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment". This percentage rating will be applied to the Injury Permanent Impairment Benefit Principal Sum shown in the **Schedule** to determine the Injury Permanent Impairment Benefit amount payable under this policy.

If an **Injury** results in **Uniplegia**, **We** will pay 100% of the Injury Permanent Impairment Principal Sum shown in the **Schedule**.

If, due to an **Injury**, the **Insured Person** has a **Permanent Impairment** rating of 90% or higher, the **Insured Person** will receive 125% of the Injury Permanent Impairment Benefit Principal Sum.

For example:

- (1) if a knee **Injury** resulted in an AMA guideline lower extremity impairment rating of 38%, which equates to 15% of the whole body, the benefit would be 15% of the Injury Permanent Impairment Benefit Principal Sum; or
- (2) if a combination of leg and back **Injuries** result in an AMA guideline whole person impairment rating of 12% and 17%, respectively, which equates to a combined whole person impairment rating of 27%, the benefit would be 27% of the Injury Permanent Impairment Benefit Principal Sum; or
- (3) if a fracture at the second cervical vertebra causes incomplete **Quadriplegia** with an AMA guideline whole person impairment rating of 93%, the benefit would be increased to 125% of the Injury Permanent Impairment Benefit Principal Sum since the impairment rating is 90% or higher.

Any Injury Permanent Impairment Benefit payable under this policy will be in addition to any Accidental Dismemberment and Paralysis Benefit or Vision Impairment Benefit payable under this policy. However, in no event will the total amount of benefit payable as the result of any one **Injury** exceed 100% of the largest Principal Sum shown in the **Schedule**, unless;

- (1) the Permanent Impairment rating for an **Injury** is 90% or higher in which case **We** will pay 125% of the Injury Permanent Impairment Principal Sum; or
- (2) an **Injury** results in **Quadriplegia**, **Paraplegia** or **Hemiplegia** in which case **We** will pay 200% of the Injury Permanent Impairment Principal Sum.

If the **Insured Person** is impaired prior to the time of **Injury**, the impairment rating that represents the pre-existing condition will be deducted from the **Permanent Impairment** evaluation due to the **Injury** as described above.

D. HEART PERMANENT IMPAIRMENT BENEFIT

If the **Insured Person** has a "Heart Permanent Impairment" due to a heart condition that results in at least 26 weeks of **Total Disability**, based upon the degree of heart impairment according to the Heart Permanent Impairment Benefit Chart shown below, **We** will pay the indicated percentage of the Heart Permanent Impairment Benefit Principal Sum shown in the **Schedule**.

To Determine the Benefit Payable

No more than nine months after the **Covered Activity**, the **Insured Person's** highest "Left Ventricular Ejection Fraction" and lowest "New York Heart Association Functional Classification" will be obtained and compared to the Heart Permanent Impairment Benefit Principal Sum shown in the **Schedule**. The ratings must result from evaluations performed after the **Covered Activity** date.

If the **Insured Person** had a "Left Ventricular Ejection Fraction" of 35% or lower prior to the **Covered Activity** date, no Heart Permanent Impairment Benefit is due.

Heart Permanent Impairment Benefit Chart

<u>Left Ventricular Ejection Fraction</u>	<u>New York Heart Association Functional Classification</u>	<u>Heart Permanent Impairment Benefit Due</u>
26 to 30% function	Class II	25%
26 to 30% function	Class III or IV	50%
21 to 25% function	Class II or III	50%
21 to 25% function	Class IV	75%
Less than 21% function	Class II or III	75%
Less than 21% function	Class IV	100%

The benefit due is calculated by multiplying the percentage due and the Principal Sum. The benefit is further modified by the **Insured Person's** age on the date of the heart impairment, according to the following table:

- Age 40 or less - 125% of amount payable
- Age 41 to 65 - 75% of amount payable
- Age 66 or over - 50% of amount payable

For example:

- (1) if a 30 year old (on the date of heart impairment) has a "Left Ventricular Ejection Fraction" of 17% and a "New York Heart Association Functional Classification" of Class IV, the benefit would be 100% of the Heart Permanent Impairment Benefit times 125% since the age is less than 40, for a total benefit of 125% of the Heart Permanent Impairment Benefit; or,
- (2) if a 55 year old (on the date of heart impairment) has a "Left Ventricular Ejection Fraction" of 19% and a "New York Heart Association Functional Classification" of Class IV, the benefit would be 100% of the Heart Permanent Impairment Benefit times 75% since the age is between 41 and 65, for a total benefit of 75% of the Heart Permanent Impairment Benefit; or,
- (3) if a 68 year old (on the date of heart impairment) has a "Left Ventricular Ejection Fraction" of 18% and a "New York Heart Association Functional" Classification of Class IV, the benefit would be 100% of the Heart Permanent Impairment Benefit times 50% since the age is 66 or over, for a total benefit of 50% of the Heart Permanent Impairment Benefit.

"Heart Permanent Impairment" - means a medical condition which is a physical and functional abnormality or loss as a consequence of an **Insured Person** sustaining a heart impairment as a result of a **Covered Activity**, resulting in: (1) a "Left Ventricular Ejection Fraction" of 30% or less; and (2) a "New York Heart Association Functional Classification" of II, III, or IV; and (3) at least 26 weeks of **Total Disability**.

"Left Ventricular Ejection Fraction" - means a clinically used measure of the percentage of blood the heart is able to eject from the left ventricle.

"New York Heart Association Functional Classification" is a standard measurement of how heart function affects activities of daily living. Below is a summary of the New York Heart Association Classification:

- I. No symptoms and no limitation in ordinary physical activity.
- II. Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
- III. Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
- IV. Severe limitations. Experiences symptoms even while at rest.

E. ILLNESS PERMANENT IMPAIRMENT BENEFIT

If **Illness** to an **Insured Person** results in five years (260 weeks) of Total Disability Benefits, **We** will pay the indicated percentage of the Illness Permanent Impairment Benefit Principal Sum shown in the **Schedule**.

To Determine the Benefit Payable

If the **Insured Person** is unable to return to his or her occupation after five years (260 weeks) of Total Disability Benefits, 50% of the Illness Permanent Impairment Benefit Principal Sum shown in the **Schedule** is payable. If the **Insured Person** is unable to return to any **Gainful Occupation** after five years (260 weeks) of Total Disability Benefits, 75% of the Illness Permanent Impairment Benefit Principal Sum shown in the **Schedule** is payable. If the **Insured Person** has been approved for Social Security disability

benefits or, if not eligible for Social Security disability benefits, otherwise meets the eligibility criteria for Social Security disability benefits, 125% of the Illness Permanent Impairment Benefit Principal Sum as shown in the **Schedule** is payable.

The five year (260 week) period of **Total Disability** does not need to be consecutive weeks but must be payable as a result of one **Illness** sustained while participating in the same **Covered Activity**.

If an **Insured Person** has received a Heart Permanent Impairment Benefit and later becomes eligible for payment under this benefit for the same condition, the amount payable under this benefit is the indicated percentage of the Illness Permanent Impairment Principal Sum shown in the **Schedule**, less the amount previously paid under the Heart Permanent Impairment Benefit. The indicated percentage described in the first paragraph of this section will also apply to the total amount payable.

F. COSMETIC DISFIGUREMENT RESULTING FROM BURNS BENEFIT

If, as the result of **Injury**, an **Insured Person** suffers a cosmetic disfigurement due to a burn that is classified as a full thickness or third degree burn, **We** will pay the indicated percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum shown in the **Schedule**.

To Determine the Benefit Payable

Any Cosmetic Disfigurement Resulting From Burns Benefit payable under this benefit will be based on a percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum shown in the **Schedule** and depend on the area of the body which was burned. The benefit payable for any one loss is determined by the following formula:

- (1) First the area of the body that was burned is assigned an area classification factor by using the chart shown below. Each body part is assigned a classification relative to its visible exposure (i.e., the more visible the exposure the higher the classification);
- (2) This area classification factor is multiplied by the percentage of body surface actually burned. The attending **Physician** will determine the percentage applicable to each burn. The chart below lists the maximum allowance percentage for body surface burned for each area classification;
- (3) Steps 1 and 2 will produce a numerical factor that will be multiplied by the Cosmetic Disfigurement Resulting From Burns Principal Sum to determine the percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable under this benefit.

For example, by using the Cosmetic Burn Chart shown below:

- (a) if 100% of the surface of the right hand and forearm were burned the benefit would be $5 \times 4.5\% = 22.5\%$ of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable; or
- (b) if 50% of the surface of the right hand and forearm were burned the benefit would be $5 \times 2.25\%$ (which is 50% of 4.5) = 11.25% of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable.

The following is a burn chart from which benefits can be determined. This chart represents the maximum percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable for a covered cosmetic disfigurement **Injury**. If the **Insured Person** suffers burns in more than one area as a result of any one **Injury**, benefits will not exceed more than 100% of the Cosmetic Disfigurement Resulting From Burns Principal Sum.

Cosmetic Burn Chart

<u>Body Part</u>	<u>Area Classification</u>	<u>Maximum Allowable % for Area Surface Burned</u>	<u>Maximum % of Cosmetic Disfigurement Resulting from Burns Principal Sum</u>
Face, Neck, Head	11	9.0%	100.0%
Hand & Forearm (Right)	5	4.5%	22.5%
Hand & Forearm (Left)	5	4.5%	22.5%
Upper Arm (Right)	3	4.5%	13.5%
Upper Arm (Left)	3	4.5%	13.5%
Torso (Front)	2	18.0%	36.0%
Torso (Back)	2	18.0%	36.0%
Thigh (Right)	1	9.0%	9.0%
Thigh (Left)	1	9.0%	9.0%
Lower Leg (Right) (below knee)	3	9.0%	27.0%
Lower Leg (Left) (below knee)	3	9.0%	27.0%

The percentage shown is based on 100% of the Body Part identified being burned. Please refer to the **Schedule** for the amount of the Cosmetic Disfigurement Resulting From Burns Principal Sum.

Any Cosmetic Disfigurement Resulting From Burns Benefit payable under this policy will be in addition to any Accidental Dismemberment and Paralysis Benefit, Vision Impairment Benefit, Injury Permanent Impairment Benefit, Heart Permanent Impairment Benefit, or Illness Permanent Impairment Benefit payable under this policy. However, in no event will the total amount of benefits payable as a result of any one **Injury** exceed 100% of the largest Principal Sum shown in the **Schedule** for these benefits.

G. HIV POSITIVE LUMP SUM LIVING BENEFIT

If, as a direct result of participation in a specific **Covered Activity**, an **Insured Person** tests "HIV Positive", **We** will pay the HIV Positive Lump Sum Living Benefit Principal Sum shown in the **Schedule**.

In the event that an HIV Positive Lump Sum Living Benefit and (1) an Illness Loss of Life Benefit or (2) an Illness Permanent Impairment Benefit are both payable under this policy as a result of any one **Illness** sustained while participating in the same **Covered Activity**, only one benefit, the largest, will be paid.

"HIV Positive" - means the presence of **HIV** antibodies in the blood of an **Insured Person** as substantiated through both a positive screening test (enzyme-linked immunosorbent assay (ELISA) and a positive supplemental test such as Western Blot. All such tests must be approved by the Food and Drug Administration (FDA) with the interpretation of positivity as specified by the manufacturer(s).

PART III. WEEKLY INCOME BENEFITS

A. TOTAL DISABILITY BENEFITS

(1) If **Injury** or **Illness** to an **Insured Person** results in **Total Disability**, **We** will pay the Total Disability Weekly Amount shown in the **Schedule** for the first 28 days of **Total Disability**.

- (2) If **Total Disability** continues beyond 28 days, **We** will pay 100% of the difference between the **Insured Person's Average Weekly Wage** and the sum of any disability income benefits paid or payable to the **Insured Person** from any Workers' Compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the Total Disability Maximum Weekly Amount shown in the **Schedule**, for each week the **Insured Person** is **Totally Disabled** up to a maximum of five years (260 weeks).
- (3) The minimum benefit payable for **Total Disability** will be the Total Disability Minimum Weekly Amount shown in the **Schedule**. If, after **Total Disability** commences, benefits are payable under a **Retirement Program**, the Total Disability Minimum Weekly Benefit does not apply.

B. PARTIAL DISABILITY BENEFITS

- (1) If **Injury** or **Illness** to an **Insured Person** results in **Partial Disability**, **We** will pay the Partial Disability Weekly Amount shown in the **Schedule** for the first 28 days of **Partial Disability**.
- (2) If **Partial Disability** continues beyond 28 days, **We** will pay 50% of the difference between the **Insured Person's Average Weekly Wage**, and the sum of any earned income, disability income benefits paid or payable to the **Insured Person** from any Workers' Compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the Partial Disability Maximum Weekly Amount shown in the **Schedule**, for each week the **Insured Person** is **Partially Disabled** up to a maximum of 52 weeks.
- (3) The minimum benefit payable for **Partial Disability** will be the Partial Disability Minimum Weekly Amount shown in the **Schedule**.

C. DISABILITY BENEFITS GENERAL

If an **Insured Person** is **Totally Disabled** or **Partially Disabled** for less than a week, **We** will pay 1/7 of the benefit otherwise payable for each full day the **Insured Person** is disabled.

The amount of Total Disability Benefits or Partial Disability Benefits payable to an **Insured Person** who is **Totally Disabled** or **Partially Disabled** will be increased after Total Disability Benefits or Partial Disability Benefits have been paid to the **Insured Person** for at least 52 consecutive weeks. Any increased benefit will become effective on July 1, following the first 52 week benefit period. Successive annual increases will be compounded on July 1 of each subsequent year. The increase will equal a minimum of 5% or the percentage increase in the **Consumer Price Index** for the preceding calendar year, whichever is greater, to a maximum of 10%. The increase will apply to either the **Insured Person's Average Weekly Wage** at the time of the **Covered Activity** which caused the **Injury** or **Illness**, or to the Total Disability Benefit or Partial Disability Benefit, whichever results in the higher benefit to the **Insured Person**.

In the event that benefits are payable for both **Total Disability** and **Partial Disability** resulting from **Injury** or **Illness** sustained while participating in the same **Covered Activity**, the maximum benefit period for all benefits is five years (260 weeks).

Periods of **Total Disability** or **Partial Disability** separated by less than five years (260 weeks) will be considered one period of disability unless due to separate and unrelated causes.

PART IV. OCCUPATIONAL RETRAINING BENEFIT

If, as a result of **Injury** or **Illness**, an **Insured Person** is not able to remain or continue in a **Gainful Occupation** and chooses to enroll in an institution of higher learning or professional or trade training program, **We** will pay for "Covered Retraining Expenses", up to the Occupational Retraining Benefit Maximum Amount shown in the **Schedule**. The objective of any professional or trade training program must be to return the **Insured Person** to work in an occupation to which he or she is suited. The professional or trade training program must be agreed upon by **Us** and the **Insured Person**.

We will pay any "Covered Retraining Expenses" incurred by an **Insured Person** in excess of benefits paid or payable under any Workers' Compensation act or similar law, no fault automobile insurance or similar law, and any **Other Valid and Collectible Insurance**.

"**Covered Retraining Expenses**" includes, but is not limited to, expenses for tuition, books, and any other training materials required by the institution of higher learning or professional or trade training program.

PART V. WEEKLY INJURY PERMANENT IMPAIRMENT BENEFIT

If **Injury** to an **Insured Person** results in a **Permanent Impairment** and, due to a covered **Injury**, it is determined that the **Insured Person** has a whole person **Permanent Impairment** percentage value of 50% or greater for purposes of the Injury Permanent Impairment Benefit, **We** will pay a Weekly Injury Permanent Impairment Benefit. This Weekly Injury Permanent Impairment Benefit will begin on the 261st week (or 521st week if the Extended Total Disability Benefit is selected) from the date of participation in the **Covered Activity** which caused the **Injury** and will continue to be paid for the remainder of the **Insured Person's** lifetime.

The Weekly Injury Permanent Impairment Benefit will be determined by multiplying the Weekly Income Benefit amount payable on the 29th day of **Total Disability**, as determined under the Weekly Income Benefits section of this policy, by the percentage value of the **Insured Person's Permanent Impairment**.

For example:

If the Total Disability Weekly Income Benefit payable on the 29th day of **Total Disability** is \$600.00 and the **Insured Person's Permanent Impairment**, due to an **Injury**, percentage value is 70%, the lifetime Weekly Injury Permanent Impairment Benefit would be \$420 per week ($\$600 \times 70\% = \420).

The **Permanent Impairment** rating due to an **Injury** used to determine the Weekly Injury Permanent Impairment Benefit is final upon initiation of Weekly Injury Permanent Impairment Benefits. Subsequent changes in the **Permanent Impairment** rating due to an **Injury** will not affect the Weekly Injury Permanent Impairment Benefits payable.

Weekly Injury Permanent Impairment Benefits will be paid in addition to any benefits payable under this policy.

PART VI. MEDICAL EXPENSE BENEFITS

A. MEDICAL EXPENSE BENEFIT

If, as a result of a covered **Injury** or **Illness**, an **Insured Person** incurs medical expenses, **We** will pay the **Reasonable and Customary Expenses** for necessary:

- (1) medical, **Hospital** or surgical treatment;
- (2) "Home Health Care";
- (3) nursing services prescribed and monitored by a **Physician**;
- (4) Post-exposure Prophylaxis Protocol (PEP) treatment, when such treatment is advised by the attending **Physician**;
- (5) **Infectious Disease** screening test(s); or
- (6) Post-exposure preventive inoculations as a result of participation in a **Covered Activity**.

We will pay the medical expense benefits subject to the **Policyholder** and/or **Participating Organization's** choice of 1 or 2 below:

- (1) If "1" in the **Schedule** is marked with an "X", **We** will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any Workers' Compensation act or similar law, or no fault automobile insurance plan or similar law. If benefits are not payable under the applicable Workers' Compensation act or similar law, but are covered under this policy, **We** will pay such benefits.
- (2) If "2" in the **Schedule** is marked with an "X", **We** will pay any covered medical expenses incurred by an **Insured Person** on a primary basis regardless of benefits paid or payable under any Workers' Compensation act or similar law, no fault automobile insurance plan or similar law, or any **Other Valid and Collectible Insurance**.

We will not pay more than the Medical Expense Benefit Maximum Amount shown in the **Schedule** for any one **Injury** or **Illness**.

"Home Health Care" - means those nursing and other home health care services provided to an **Insured Person** in his or her place of residence. "Home Health Care" must be:

- (1) performed by a "Home Health Care Practitioner";
- (2) in lieu of confinement in a **Hospital** or nursing facility; and
- (3) pursuant to the orders of the attending **Physician**. Such attending **Physician's** orders must be written and include a plan of care which must be reviewed and approved by the **Physician**.

"Home Health Care Practitioner" - means a nurse, medical social worker, home health aide, physical therapist, or other medical practitioner. However, no provider will be considered a "Home Health Care Practitioner" unless such practitioner is:

- (1) duly licensed and/or certified in compliance with all applicable laws and regulations to provide the care received; and
- (2) not an **Insured Person** or an **Immediate Family Member**.

B. COSMETIC PLASTIC SURGERY BENEFIT

If an **Insured Person** requires skin grafting or plastic surgery due to an **Injury** for which Medical Expense Benefits are payable, **We** will pay the **Reasonable and Customary Expense(s)** incurred. **We** will not pay more than the Cosmetic Plastic Surgery Maximum Amount shown in the **Schedule** for any one **Injury**.

C. POST-TRAUMATIC STRESS DISORDER BENEFIT

If, as the result of participation in a specific **Covered Activity** in which a **Traumatic Incident** occurred while coverage under this policy is in force, an **Insured Person** requires **Medical Treatment** for a **Post-Traumatic Stress Disorder**, **We** will pay the **Reasonable and Customary Expense(s)** incurred. Treatment must be prescribed and monitored by a **Physician**. **We** will not pay more than the Post-Traumatic Stress Disorder Maximum Amount shown in the **Schedule** for each **Insured Person** for any one **Covered Activity**.

D. CRITICAL INCIDENT STRESS MANAGEMENT BENEFIT

If a "Critical Incident Stress Management Team" is requested and authorized by the **Policyholder** and/or **Participating Organization** and is required as a result of the **Insured Person's** participation in a specific **Covered Activity** in which a **Traumatic Incident** occurred while coverage under this policy is in force, **We** will pay the reasonable expenses incurred by a "Critical Incident Stress Management Team". Covered expenses include, but are not limited to, the cost of necessary transportation, meals, and lodging. **We** will not pay more than the Critical Incident Stress Management Maximum Amount which is shown in the **Schedule** regardless of the number of **Insured Persons** treated.

"Critical Incident Stress Management Team (CISMT)" - means a formally organized group of mental health professionals and peer support individuals trained to provide support services to emergency service personnel. Such support services include stress debriefing, defusing, demobilization, stress education, spousal support, one-on-one interviews, or on the scene support.

E. FAMILY EXPENSE BENEFIT

If an **Insured Person** is admitted to the **Hospital** as an inpatient due to a covered **Injury** or **Illness**, **We** will pay the Family Expense Benefit shown in the **Schedule** for each day of such **Hospital** confinement.

After such **Hospital** confinement, **We** will also pay 50% of the Family Expense Benefit shown in the **Schedule** for each day an **Insured Person** participates in **Out-Patient Physical Therapy** as a result of such **Injury** or **Illness**.

The Family Expense Benefit will be payable for a combined maximum of 26 weeks for any one **Injury** or **Illness** regardless of whether it is paid at 100% or 50%.

F. FAMILY BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

If an Accidental Death or Illness Loss of Life Benefit is payable under this policy or if an **Insured Person's** participation in a specific **Covered Activity** in which a **Traumatic Incident** occurred while coverage under this policy is in force and a **Dependent Child** or "Resident" **Immediate Family Member**, of an **Insured Person** requires counseling, **We** will pay the reasonable expense(s) incurred for counseling. Treatment must be prescribed and monitored by a **Physician**. **We** will not pay more than the Family Bereavement and Trauma Counseling Benefit Maximum Amount shown in the **Schedule** for each **Dependent Child** or "Resident" **Immediate Family Member** for any one **Covered Activity**.

“Resident” - means that the **Immediate Family Member’s** domicile is at the home of the **Insured Person**. A domicile is where the **Immediate Family Member’s** permanent home is located or the place the **Immediate Family Member** intends to return to after a short-term absence, such as, but not limited to; vacation, business assignment, college, military assignment.

PART VII. TRANSITION BENEFIT

If, while the **Insured Person** is receiving Total Disability benefits under this policy, he or she is involuntarily terminated from his or her regular employment and so remains unemployed after his or her Total Disability benefits end under this policy, and the Transition Benefit is indicated in the **Schedule**, **We** will pay a weekly Transition Benefit equivalent to the last Total Disability Weekly Amount. **We** will pay this Transition Benefit as long as the **Insured Person** remains unemployed up to a maximum of 26 weeks.

PART VIII. FELONIOUS ASSAULT BENEFIT

If an **Insured Person** suffers a covered **Injury** or **Illness** as a result of a “Felonious Assault” that is directed at the **Insured Person** while he or she is participating in a **Covered Activity**, and one or more of the following are payable: Accidental Death Benefit, Illness Loss of Life Benefit, Accidental Dismemberment and Paralysis Benefit, Vision Impairment Benefit, Injury Permanent Impairment Benefit, Heart Permanent Impairment Benefit, Illness Permanent Impairment Benefit, Cosmetic Disfigurement Resulting from Burns Benefit, or HIV Positive Lump Sum Living Benefit as provided by this policy, and the Felonious Assault Benefit is indicated in the **Schedule**, **We** will pay the Felonious Assault Benefit Amount.

We will not pay more than the Felonious Assault Benefit Amount shown in the **Schedule** per **Insured Person**.

“Felonious Assault” will not apply to a Police Officer while acting within the scope of his or her employment.

“Felonious Assault” - means any willful or unlawful use of force upon the **Insured Person**:

- (1) with the intent to cause bodily injury to the **Insured Person**; and
- (2) that results in bodily harm to the **Insured Person**; and
- (3) that is a felony or a misdemeanor in the jurisdiction in which it occurs.

PART IX. HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

If an **Insured Person**:

- (1) suffers an **Injury** or **Illness** that is payable under this policy and which results in a permanent and irrevocable loss;
- (2) did not, prior to the date of the **Covered Activity**, require alterations to the home and/or modifications to the vehicle; and
- (3) as a direct result of such **Injury** or **Illness** is now required to make alterations to the home and/or modifications to the vehicle;

We will pay the Home Alteration and Vehicle Modification Benefit for “Home Alteration and Vehicle Modification Expenses” that are incurred within three years after the date of the **Injury** or **Illness**, up to the Home Alteration and Vehicle Modification Maximum Amount shown in the **Schedule**, for all such losses caused by the same **Injury** or **Illness**.

We will pay any “Home Alteration and Vehicle Modification Expenses” incurred by an **Insured Person** in excess of benefits paid or payable under any Workers’ Compensation act or similar law, no fault automobile insurance plan or similar law, and any **Other Valid and Collectible Insurance**.

“Home Alteration and Vehicle Modification Expenses” - means one-time expenses that:

- (1) are charged for:
 - (a) alterations to the **Insured Person’s** residence that are necessary to make the residence accessible and habitable for an impaired individual; and
 - (b) modifications to a motor vehicle owned or leased by the **Insured Person** or modifications to a motor vehicle newly purchased for the **Insured Person** that are necessary to make the vehicle accessible to and/or drivable by the **Insured Person**; and
- (2) do not include charges that would not have been made if no insurance existed; and
- (3) do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred;

but only if the alterations to the **Insured Person’s** residence and the modifications to his or her motor vehicle are:

- (1) made on behalf of the **Insured Person**;
- (2) in compliance with any applicable laws or requirements for approval by the appropriate government authorities; and
- (3) agreed to and approved by **Us**.

PART X. OPTIONAL BENEFITS

A. WEEKLY HOSPITAL BENEFIT

If Weekly Income Benefits are payable under this policy and the Weekly Hospital Benefit is indicated in the **Schedule**, **We** will also pay the Weekly Hospital Benefit shown in the **Schedule** if the **Insured Person** eligible to receive the Weekly Income Benefits requires **Hospital** confinement or **Out-Patient Physical Therapy** for the same **Injury** or **Illness**.

The Weekly Hospital Benefit starts on the first day the **Insured Person** is confined to a **Hospital** or begins **Out-Patient Physical Therapy**. If benefits are payable for less than a full week, **We** will pay 1/7 of the Weekly Hospital Benefit shown in the **Schedule** for each day the **Insured Person** is confined in the **Hospital** or receives **Out-Patient Physical Therapy**. This benefit will be limited to a maximum of 104 weeks for all **Injuries** or **Illnesses** resulting from the same **Covered Activity**.

If the **Insured Person** is in an intensive, cardiac or critical care unit, the Weekly Hospital Benefit Amount shown in the **Schedule** is doubled.

B. FIRST WEEK TOTAL DISABILITY BENEFIT

If an **Insured Person** becomes **Totally Disabled** and is eligible for Total Disability Benefits under this policy and the First Week Total Disability Benefit is indicated in the **Schedule**, **We** will pay a one-time additional weekly benefit equal to the First Week Total Disability Benefit Amount shown in the **Schedule** for the first week the **Insured Person** is **Totally Disabled**. If the **Insured Person** is **Totally Disabled** for less than one week, **We** will pay 1/7 of the First Week Total Disability Benefit Amount for each full day of **Total Disability**. **We** will pay the First Week Total Disability Benefit Amount in addition to any other weekly benefit payable under this policy.

C. COORDINATED 28 DAY TOTAL DISABILITY BENEFIT

If an **Insured Person** becomes **Totally Disabled** and is eligible for Total Disability Benefits under this policy and the Coordinated 28 Day Total Disability Benefit is indicated in the **Schedule**, **We** will pay 100% of the difference between the **Insured Person's Average Weekly Wage** and the sum of the Total Disability Weekly Amount (first 28 days) payable under this policy and any disability income benefits received by the **Insured Person** from any Workers' Compensation act or similar law not to exceed the Coordinated 28 Day Total Disability Benefit Maximum Amount shown in the **Schedule**, for each week the **Insured Person** is **Totally Disabled**. This benefit is payable for the first 28 days of **Total Disability**.

If the **Insured Person** is **Totally Disabled** for less than one week, **We** will pay 1/7 of the Coordinated 28 Day Total Disability Benefit for each full day of **Total Disability**.

D. EXTENDED TOTAL DISABILITY BENEFIT

If an **Insured Person** is **Totally Disabled** and the Extended Total Disability Benefit is indicated in the **Schedule**, **We** will increase the maximum benefit period as indicated under the Total Disability Benefit from five years (260 weeks) to 10 years (520 weeks).

E. LONG-TERM TOTAL DISABILITY BENEFIT

If an **Insured Person** meets the definition of **Long-Term Total Disability** and the Long-Term Total Disability Benefit is indicated in the **Schedule**, **We** will increase the maximum benefit period as indicated under the Extended Total Disability Benefit from 10 years (520 weeks) to age 70.

The Long-Term Total Disability Benefit amount payable will be based on the Weekly Income Benefit Amount payable on the 29th day of **Total Disability**, plus annual compounded increases, offset by any Weekly Injury Permanent Impairment Benefit payable for the same loss.

The following paragraph is hereby added under Disability Benefits General as follows:

If an **Insured Person** becomes able to return to their regular occupation or becomes otherwise employed, benefits under **Long-Term Total Disability** will cease.

F. COST OF LIVING ADJUSTMENT (COLA) BENEFITS

(1) Weekly Injury Permanent Impairment COLA

(2) Long-Term Total Disability COLA

If Weekly Injury Permanent Impairment COLA or Long-Term Total Disability COLA Benefit is indicated in the **Schedule** and the Weekly Injury Permanent Impairment Benefit or the Long-Term Total Disability Benefit becomes payable under this policy, the amount payable will be increased annually after benefits have been paid for at least 52 consecutive weeks. Any increased benefit will become effective on July 1, following the first 52 week benefit period. Successive annual increases will be compounded on July 1 of each subsequent year. The increase will equal a minimum of 5% or the percentage increase in the **Consumer Price Index** for the preceding calendar year, whichever is greater, to a maximum of 10%.

G. EXTRA EXPENSE BENEFIT

After 26 weeks of an **Insured Person's Total Disability** due to a covered **Injury** or **Illness**, **We** will pay the Extra Expense Benefit Monthly Amount shown in the **Schedule**. This benefit will cease when the **Insured Person** is no longer **Totally Disabled**. **We** will not pay more than the Extra Expense Benefit Maximum Amount shown in the **Schedule**.

If an **Insured Person** is **Totally Disabled** for less than a month, **We** will pay 1/28 of the benefit otherwise payable for each full day the **Insured Person** is disabled.

H. 24-HOUR ACCIDENT BENEFIT – INJURY ONLY

24-Hour Accidental Death Benefit. **We** will pay the 24-Hour Accident Benefit Amount shown in the **Schedule** if bodily injury to a **Covered Person** results in the **Covered Person's** death.

24-Hour Accidental Dismemberment and Paralysis or Vision Impairment Benefit. In the event of dismemberment, paralysis or vision impairment the amount payable under this benefit will be calculated based on the 24-Hour Accident Benefit Amount indicated in the **Schedule** and the percentage indicated on the Accidental Dismemberment and Paralysis Chart or the Vision Impairment Chart.

We will pay the 24-Hour Accident Benefit Amount, as described above, when a **Covered Person** suffers a bodily injury at any time, whether during a **Covered Activity** or not, that results in the **Covered Person's** accidental death, dismemberment, paralysis or vision impairment. Any 24-Hour Accident Benefit payable is in addition to any Accidental Death Benefit, Accidental Dismemberment and Paralysis Benefit or Vision Impairment Benefit payable under this policy.

In no event will the total amount of benefits payable as a result of any one bodily injury exceed 100% of the largest Benefit Amount for a 24-Hour Accidental Death, and/or a 24-Hour Accidental Dismemberment and Paralysis and/or a Vision Impairment. **We** will not pay more than 100% of the 24-Hour Accident Benefit Amount shown in the **Schedule**, or the indicated percentage on the Accidental Death, Dismemberment and Paralysis Chart per **Covered Person**, whichever is greater.

In no event will both, a 24-Hour Benefit and an Off-Duty Accident Benefit be provided under this policy.

I. OFF-DUTY ACCIDENT BENEFIT - INJURY ONLY

Off-Duty Accidental Death Benefit. **We** will pay the Off-Duty Accident Benefit Amount shown in the **Schedule** if bodily injury to a **Covered Person** results in the **Covered Person's** death.

Off-Duty Accidental Dismemberment and Paralysis or Vision Impairment Benefit. In the event of dismemberment, paralysis or vision impairment the amount payable under this benefit will be calculated based on the Off-Duty Accident Benefit Amount indicated in the **Schedule** and the percentage indicated on the Accidental Dismemberment and Paralysis Chart or the Vision Impairment Chart.

We will pay the Off-Duty Accident Benefit, as described above, when a **Covered Person** suffers a bodily injury that does not occur during a **Covered Activity**, that results in the **Covered Person's** accidental death, dismemberment, paralysis or vision impairment.

In no event will the total amount of benefits payable as a result of any one bodily injury exceed 100% of the largest Benefit Amount for an Off-Duty Accidental Death, and/or an Off-Duty Accidental Dismemberment and Paralysis and/or a Vision Impairment. **We** will not pay more than 100% of the Off-Duty Accident Benefit Amount shown in the **Schedule**, or the indicated percentage on the Accidental Death, Dismemberment and Paralysis Chart per **Covered Person**, whichever is greater.

In no event will both, an Off-Duty Benefit and a 24-Hour Accident Benefit be provided under this policy.

EXCLUSIONS

We will not cover any loss caused by or resulting from:

- (1) suicide or any attempt at it; or intentionally self-inflicted injuries;
- (2) injuries that happen while flying except;
 - (a) as a passenger on a commercial aircraft;
 - (b) as a passenger on any aircraft while taking part in a **Covered Activity**;
- (3) injuries that happen while flying as a crew member, or during parachute jumps from the aircraft;
- (4) war or any act of war, whether declared or undeclared;
- (5) mental or emotional disorders, except as specifically provided for covered **Post-Traumatic Stress Disorder**;
- (6) treatment of alcoholism or drug addiction and any complications arising from it, except loss caused by **Injury** sustained during and resulting from a **Covered Activity**;
- (7) illness, except as provided by this policy;
- (8) military service of any state or country;
- (9) any form of football, hockey, lacrosse, soccer, boxing, rugby and martial arts;
- (10) any league sports event, except as covered under the Organized Team Sports Rider or
- (11) "Cancer".

"Cancer" - means any disease in which abnormal, unregulated cell growth forms malignant tumors and/or invades nearby tissues. This includes, but is not limited to: carcinoma, sarcoma, leukemia, lymphoma and multiple myeloma, and central nervous system cancers.

OTHER COVERAGE WITH US

If the **Insured Person** is covered under more than one similar policy issued by **Us**, the total benefits payable will not exceed those payable under the policy which provides the largest benefit.

GENERAL PROVISIONS

Entire Contract; Changes: The policy, application(s), riders, endorsements, amendments, or other attached papers make up the entire contract between the **Policyholder** and/or **Participating Organization** and **Us**.

No change in this policy will be valid until approved by one of **Our** executive officers. Such approval must be noted on or attached to the policy. No agent may change or waive any of the provisions of the policy.

Statements: In the absence of fraud, all statements made by the **Policyholder** and/or **Participating Organization** or any **Insured Person** will be considered representations and not warranties. No statement will be used to void the insurance or reduce benefits unless they appear in a written instrument signed by the **Policyholder** and/or **Participating Organization** and unless a copy of the statement is furnished to the **Insured Person**, his or her beneficiary or personal representative.

Incontestability: The validity of this policy will not be contested after it has been in force for two year(s) from the policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums.

Grace Period: This policy has a 31 day grace period. This means if the premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period this policy will remain in force.

Notice of Claim: Written notice of claim must be given to **Us** within 30 days after a covered loss occurs, or as soon after as reasonably possible. The notice can be given by or on behalf of the **Insured Person** to **Us** at **Our** executive offices or to one of **Our** authorized agents with sufficient information to identify the **Insured Person**, will be deemed notice to **Us**.

Claim Forms: When **We** receive the written notice of claim, **We** will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after receipt of such notice, the claimant will need to meet the proof of loss requirements by giving **Us** written proof of the occurrence, the nature, and the extent of the loss within the time limit stated in the "Proof of Loss" Section. The notice should include the **Insured Person's** name, the **Policyholder** and/or **Participating Organization's** name, and the Policy Number.

Proof of Loss: Proof must be given as soon as reasonably possible. If this policy provides for periodic payment for a continuing loss, **We** must be given written proof within 90 days after the end of each period for which **We** are liable. For any other loss, **We** must be given written proof within 90 days after that loss. If it was not reasonably possible to give written proof in the time required, **We** will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible.

Time of Payment of Claims: When **We** receive written proof of loss, **We** will pay any benefits due. Benefits that provide for periodic payment will be paid at least monthly. When **Our** liability ends, **We** will pay any remaining balance as soon as **We** receive written proof of loss.

Payment of Claims: Any Loss of Life Benefit will be paid in accordance with the beneficiary designation on record with **Us** or the **Policyholder** and/or **Participating Organization**.

If no beneficiary is named, Loss of Life Benefits will be paid to the first surviving class of the following classes: the **Insured Person's** (1) spouse; (2) child(ren); (3) parents; or (4) brothers or sisters. Otherwise, **We** will pay benefits to the **Insured Person's** estate.

All other benefits are payable to the **Insured Person**, unless otherwise indicated in this policy. **We** may pay all or a part of any benefits for health care services directly to the provider. **We** cannot require that the service be given by a certain provider.

If the **Policyholder** and/or **Participating Organization** requests, **We** may (at **Our** option) pay benefits to the **Policyholder** and/or **Participating Organization**. The **Policyholder** and/or **Participating Organization** will then pay the **Insured Person** or beneficiary entitled to receive the benefits.

Any payment **We** make in good faith will end **Our** liability to the extent of the payment.

Physical Examination and Autopsy: **We**, at **Our** expense, have the right to have the **Insured Person** examined as often as reasonably necessary while a claim is pending under this policy. **We** may also have an autopsy performed unless prohibited by law.

Legal Actions: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after three years from the time written proof of loss is required to be given.

Change of Beneficiary: The **Insured Person** can change the beneficiary at any time by sending a written notice to the **Policyholder** and/or **Participating Organization**. The beneficiary's consent is not required for this or any other change in this policy, unless the designation of the beneficiary is irrevocable.

Conformity with State Statutes: Any provision of this policy, which, on its effective date, is in conflict with the laws of the state in which the **Insured Person** resides on that date, is amended to conform to the minimum requirements of such laws.

Clerical Error: The insurance of any **Insured Person** will not be affected by a clerical error made by the **Policyholder** and/or **Participating Organization** or **Us**. An error will not continue the insurance of an **Insured Person** beyond the date it would end under the policy terms if the error had not been made.

Examination and Audit: **We** will be permitted to examine and audit a **Policyholder** and/or **Participating Organization's** records relating to this policy at: (1) any reasonable time during the policy term; and (2) within two years after the expiration of the policy or until all claims have been settled or adjusted, whichever is later.

New Entrants: New eligible persons added from time to time to the group of **Insured Persons** originally insured under this plan will be automatically covered under this policy.

Duty to Cooperate: The **Policyholder**, **Participating Organization** and the **Insured Person** will cooperate with **Us** and assist **Us**, as **We** request, in the investigation of any claim reported under this policy. Neither the **Policyholder**, **Participating Organization** nor the **Insured Person** will voluntarily make payments, assume obligations, or incur expenses, except at the cost of the **Policyholder**, **Participating Organization** or the **Insured Person**.

Not In Lieu Of Workers' Compensation: This policy is not a Workers' Compensation policy. It does not provide Workers' Compensation Benefits.

Noncompliance with Policy Requirements: Any express waiver by **Us** of any requirements of this policy will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any policy provision will not operate as a waiver or amendment of that provision.

Misstatement of Age: If the benefits for which the **Insured Person** is insured are based on age and the **Insured Person** has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. **We** may require satisfactory proof of age before paying any claim.

Assignment: This policy is non-assignable. An **Insured Person** may not assign any of his or her rights, privileges or benefits under this policy.

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038

(212) 458-5000

(a capital stock company, herein referred to as the Company)

Policyholder: APPALACHIAN SEARCH AND RESCUE CONFERENCE, INC
Policy Number: VFP-4347-4905E-4
Effective Date: 2/1/2020

VIRGINIA RESIDENTS RIDER

This rider is attached to and made a part of the above mentioned policy. It applies only with respect to **Injuries** or **Illnesses** that occur on or after the effective date shown above. Any changes in premium apply as of the effective date of this rider. This rider is subject to all of the provisions, benefits, limitations and exclusions of the policy except as they are specifically modified by this rider. If there is a conflict between the policy and this rider, the terms of this rider will govern. This rider amends the policy in the following manner:

1. The reference to "no fault automobile insurance or similar law" is removed from the definition of Other Valid and Collectible Insurance, Occupational Retraining Benefit, Medical Expense Benefits and Home Alteration and Vehicle Modification Benefit.
2. The **GENERAL PROVISIONS** section is modified as follows:

The following Provisions are replaced:

Incontestability: The validity of this policy will not be contested after it has been in force for two year(s) from the policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums. No statement will be used to contest the validity of this policy after it has been in force prior to the contest for two years and the statement is contained in a written statement signed by the Insured.

Notice of Claim: Written notice of claim must be given to **Us** within 30 days after a covered loss occurs, or as soon after as reasonably possible. The notice can be given by or on behalf of the **Insured Person** to **Us** at **Our** executive offices or to one of **Our** authorized agents with sufficient information to identify the **Insured Person**, will be deemed notice to **Us**. If it was not reasonably possible to give written notice in the time required, **We** will not reduce or deny the claim for this reason, if the notice is filed as soon as reasonably possible.

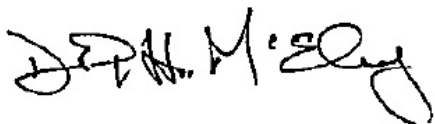
Proof of Loss: Proof must be given as soon as reasonably possible. If the policy provides for periodic payment for a continuing loss, **We** must be given written proof within 90 days after the end of each period for which **We** are liable and subsequent written proofs of continuance of such disability must be furnished to **Us** at such intervals as **We** may reasonably require. For any other loss, **We** must be given written proof within 90 days after that loss. If it was not reasonably possible to give written proof in the time required, **We** will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible.

Time of Payment of Claims: Subject to **Our** receipt of written proof of loss, for other than loss of time, **We** will pay any benefits due within 60 days after the receipt of the proof of loss. Benefits that provide for periodic payment will be paid at least monthly. When **Our** liability ends, **We** will pay any remaining balance as soon as **We** receive written proof of loss.

3. The following Provision is added.

Claims Experience Disclosure: We, upon request, shall provide the **Policyholder** and/or **Participating Organization** with a complete record of the **Policyholder** and/or **Participating Organization's** medical claims experience or medical costs incurred under the policy. The record will be made available promptly to the **Policyholder** and/or **Participating Organization** upon request made not less than 30 days prior to the date upon which the premiums or contractual terms of the policy may be amended.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this rider:

A handwritten signature in black ink, appearing to read "J. H. M. 2011", written over a light blue rectangular background.

President

A handwritten signature in black ink, consisting of stylized initials, written over a light blue rectangular background.

Secretary

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038
(212) 458-5000

(a capital stock company, herein referred to as the Company)

Policyholder: APPALACHIAN SEARCH AND RESCUE CONFERENCE, INC
Policy Number: VFP-4347-4905E-4
Effective Date: 2/1/2020

MANDATORY QUARANTINE RIDER

This rider is attached to and made a part of the above mentioned policy. It applies only with respect to **Injuries** or **Illnesses** that occur on or after the effective date shown above. Any changes in premium apply as of the effective date of this rider. This rider is subject to all of the provisions, benefits, limitations and exclusions of the policy except as they are specifically modified by this rider. If there is a conflict between the policy and this rider, the terms of this rider will govern. This rider amends the policy in the following manner:

1. The **DEFINITIONS** section is modified as follows:

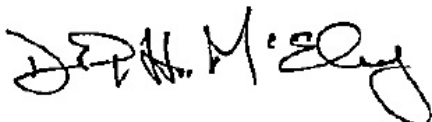
The following is added to the definition of **Illness**:

(3) Illness also includes the **Mandatory Quarantine** of an **Insured Person**.

The following definition is added:

Mandatory Quarantine - means period of isolation intended to limit the spread of an **Infectious Disease**. The **Mandatory Quarantine** of an **Insured Person** must be ordered by appropriate medical officials while acting under the authority of the local, state or federal government.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this rider:



President



Secretary

**NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association (“the Association”) and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
 - o \$300,000 in death benefits
 - o \$100,000 in cash surrender or withdrawal values
- Health Insurance
 - o \$500,000 for health benefit plans
 - o \$300,000 in disability income insurance benefits
 - o \$300,000 in long-term care insurance benefits
 - o \$100,000 in other types of accident and sickness insurance benefits
- Annuities
 - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$350,000, except for health benefit plans, for which the limit is increased to \$500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association’s website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
<http://scc.virginia.gov/boi/index.aspx>

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to 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 Virginia law, then Virginia law will control.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

**National Union Fire Insurance Company of Pittsburgh, Pa.
A&H Claims Department
P.O. Box 25987
Shawnee Mission, Kansas 66225
1-800-551-0824**

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

**Bureau of Insurance
State Corporation Commission
P.O. Box 1157
Richmond, Virginia 23218
Toll-free number for Virginia residents: 800-552-7945
Local Number: 804-371-9691
Toll-free number for Out of State calls: 877-310-6560**

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038
(212) 458-5000

(a capital stock company, herein referred to as the Company)

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

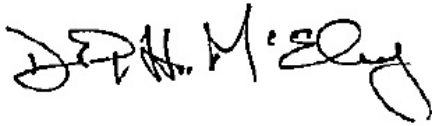
ENDORSEMENT

This endorsement, effective 12:01 A.M. 2/1/2020 forms a part of Policy No. VFP-4347-4905E-4 issued to APPALACHIAN SEARCH AND RESCUE CONFERENCE, INC by National Union Fire Insurance Company of Pittsburgh, PA.

ECONOMIC SANCTIONS ENDORSEMENT

This endorsement modifies insurance provided under the following:

The Insurer shall not be deemed to provide cover and the Insurer shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Insurer, its parent company or its ultimate controlling entity to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union or the United States of America.



President



Secretary

**IMPORTANT NOTICE TO OUR CUSTOMERS
REGARDING THE
OFFICE OF FOREIGN ASSETS CONTROL ("OFAC")**

Your rights as a policyholder and payments to you, any insured, additional insured, loss payee, mortgagee, or claimant, for loss under this policy may be affected by the administration and enforcement of U.S. economic embargoes and trade sanctions by the OFFICE OF FOREIGN ASSETS CONTROL ("OFAC").

The United States imposes economic sanctions against countries, groups and individuals, such as terrorists and narcotics traffickers. These sanctions prohibit US persons from dealing with these sanctioned parties. The purpose of this notice is to inform you that we cannot violate US sanctions by engaging with sanctioned countries or people.

WHAT IS OFAC?

OFAC is an office of the Department of the Treasury and acts under presidential wartime and national emergency powers, as well as authority granted by specific legislation, to impose controls on transactions and freeze foreign assets under U.S. jurisdiction. OFAC administers and enforces economic embargoes and trade sanctions primarily against:

- Targeted foreign countries and their agents
- Terrorism sponsoring agencies and organizations
- International narcotics traffickers
- Proliferators of Weapons of Mass Destruction

PROHIBITED ACTIVITY

- OFAC enforces certain embargoes and sanctions against designated countries. No U.S. business or person may enter into transactions involving designated "sanctioned" countries.
- OFAC publishes on its website a list known as the "Specially Designated Nationals and Blocked Persons" ("SDNBP") list. No U.S. business or person may enter into transactions involving any person or entity named on the SDNBP list.

Additional information about OFAC Sanctions Programs and Countries can be found at:

<http://www.treasury.gov/resource-center/sanctions/Programs/Pages/Programs.aspx>

OBLIGATIONS PLACED ON US BY OFAC

If we determine that you or any insured, additional insured, loss payee, mortgagee, or claimant are on the SDNBP list or are connected to a sanctioned country as described in the regulations, we must block or "freeze" property and payment of any funds transfers or transactions.

POTENTIAL ACTIONS BY US

1. We shall not be deemed to provide cover when it would violate any applicable sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union or the United States of America. You will not receive a return premium unless approved by OFAC. All funds will be placed in an interest bearing blocked account established on the books of a U.S. financial institution.
2. We will not pay a claim or provide any benefit to the extent that such cover, payment of such claim or provision of such benefit would violate any trade or economic sanctions, laws or regulations of the United States of America and we will not defend or provide any other benefits under your policy to individuals, entities or companies to the extent that it would violate any trade or economic sanctions, laws or regulations of the United States of America.

YOUR RIGHTS AS A POLICYHOLDER

If funds are blocked or frozen by us in conjunction with the OFFICE OF FOREIGN ASSETS CONTROL, you may complete an "APPLICATION FOR THE RELEASE OF BLOCKED FUNDS" and apply for a specific license to request their release. Forms are available for download at the OFAC website. See

<https://www.treasury.gov/resource-center/sanctions/Pages/forms-index.aspx>

Edition Date: 5/2016

POLICYHOLDER NOTICE

Thank you for purchasing insurance from a member company of American International Group, Inc. (AIG). The AIG member companies generally pay compensation to brokers and independent agents, and may have paid compensation in connection with your policy. You can review and obtain information about the nature and range of compensation paid by AIG member companies to brokers and independent agents in the United States by visiting our website at www.aig.com/producer-compensation or by calling 1-800-706-3102.