ACE INA PRIVACY STATEMENT

The ACE INA group of companies strongly believes in maintaining the privacy of information we collect about individuals. We want you to understand how and why we use and disclose the collected information. The following provides details of our practices and procedures for protecting the security of nonpublic personal information that we have collected about individuals. This privacy statement applies to policies underwritten by ACE American Insurance Company.

INFORMATION WE COLLECT

The information we collect will vary depending on the type of product or service individuals seek or purchase, and may include:

- Information we receive from individuals, such as their name, address, age, phone number, social security number, assets, income, or beneficiaries;
- Information about individuals' transactions with us, with our affiliates, or with others, such as policy coverage, premium, payment history, motor vehicle records; and
- Information we receive from a consumer reporting agency, such as a credit history.

INFORMATION WE DISCLOSE

We do not disclose any personal information to anyone except as is necessary in order to provide our products or services to a person, or otherwise as we are required or permitted by law.

We may disclose any of the information that we collect to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

THE RIGHT TO VERIFY THE ACCURACY OF INFORMATION WE COLLECT

Keeping information accurate and up to date is important to us. Individuals may see and correct their personal information that we collect except for information relating to a claim or a criminal or civil proceeding.

CONFIDENTIALITY AND SECURITY

We restrict access to personal information to our employees, our affiliates' employees, or others who need to know that information to service the account or in the course of conducting our normal business operations. We maintain physical, electronic, and procedural safeguards to protect personal information.

CONTACTING US

If you have any questions about this privacy statement or would like to learn more about how we protect privacy, please write to us at ACE INA Customer Services, P.O. Box 1000, 436 Walnut Street, WA04F, Philadelphia, PA 19106. Please include the policy number on any correspondence with us.


ACE American Insurance Company

NOTICE CONCERNING INSURANCE COMPLAINTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? Your satisfaction is very important to us. If you are having problems with your insurance, do not hesitate to contact the insurance company to resolve your problem.

ACE American Insurance Company
ACE USA Customer Service Department
P.O. Box 1000
Philadelphia, Pennsylvania 19105-1000
1-800-352-4462

If we at ACE American Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact the ARKANSAS INSURANCE DEPARTMENT and file a complaint. You can contact the ARKANSAS INSURANCE DEPARTMENT BY contacting:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-501-371-2640
1-800-852-5494

Please include your policy number in any communication with the above addresses.

ACE American Insurance Company
Philadelphia, PA 19106

Group Limited Accident and Sickness Certificate of Insurance

POLICYHOLDER:	Trustee of the ACE USA Accident & Health Insurance Trust on behalf of Participating Organization
PARTICIPATING ORGANIZATION:	Dillards Department Stores
POLICY NUMBER:	LMB N04855474

This Certificate of Insurance is issued under the terms of the Policy issued to the Participating Organization. We insure each person in one of the Classes of Eligible Persons provided the required premium is paid when due.

We will pay the benefits described in the Policy for losses and expenses incurred:
1. while the Policy is in force and Your coverage is in effect; and
2. subject to all the provisions, conditions, exclusions and limitations of the Policy.

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania

JOHN J. LUPICA, President

CARMINE A. GIGANTI, Secretary

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THIS IS A CERTIFICATE OF INSURANCE FOR A FIXED INDEMNITY POLICY.
IT PAYS BENEFITS REGARDLESS OF ANY OTHER INSURANCE. IT IS NOT MAJOR MEDICAL OR COMPREHENSIVE MEDICAL HEALTHCARE INSURANCE.
PLEASE READ THE CERTIFICATE OF INSURANCE CAREFULLY.

SCHEDULE OF BENEFITS

You are eligible for coverage if You are an employee of the Participating Organization who is in Active Service, working more than 20 hours per week and have completed 30 days of employment.

Your Dependents are eligible for coverage if coverage is elected in the Enrollment Form.

Plan 2

Daily Hospital Confinement	$1,000 for first day confined per Plan Year $500 per day thereafter, up to a maximum of 4 days per Plan Year
Daily Intensive Care Unit	Additional $500 per day to a maximum of 4 days per Plan Year
Emergency Room Visits	
Sickness	$250 per visit to a maximum of 2 visits per Plan Year
Surgery Benefit	
Outpatient	$250 per Outpatient Surgery to a maximum of 1 surgeries per Plan Year
Anesthesia Benefit:	25% of the Surgery Benefit

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

"Active Service" means a Covered Person is either 1) actively at work performing all regular duties either at his or her employer's place of business or someplace the employer requires him or her to be; or 2) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

"Benefit Period" means the period of time when benefits are payable. Benefits are payable on a Plan Year basis.

"Covered Accident" means an accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

"Covered Expenses" means expenses actually incurred by or on behalf of a Covered Person for services or supplies covered by the Policy. A Covered Expense is deemed to be incurred on the date such service or supply that gave rise to the expense or the charge, was rendered or obtained.

"Covered Loss" or "Covered Losses" means an accidental death, dismemberment or other loss resulting from Injury or Sickness covered under the Policy.

"Covered Person" means any eligible person, including Dependents if eligible for coverage under the Policy, and for whom the required premium is paid. If the cost for insurance is paid by the Participating Organization, individual applications are not required for an eligible person to be a Covered Person.

"Dependent" means an Insured's lawful spouse; or an Insured's child, from the moment of birth to age 26. A child, for eligibility purposes, includes an Insured's natural child; adopted child, beginning with any waiting period pending finalization of the child's adoption; or a stepchild. A Dependent may also include any person related to the Insured by blood or marriage and for whom the Insured is allowed a deduction under the Internal Revenue Code.

Insurance will continue for any Dependent child who reaches the age limit and continues to meet the following conditions: 1) the child is handicapped, 2) is not capable of self-support and 3) depends mainly on the Insured for support and maintenance. The Insured must send Us satisfactory proof that the child meets these conditions, when requested. We will not ask for proof more than once a year.

If the Insured has elected coverage for a Dependent child, any newly born child of the Insured will be covered from the moment of birth for 31 days. Coverage may be continued beyond this time period if the Insured notifies Us within 31 days of the child's birth and pays any required premium.

"Dependent" also means an Insured's Domestic Partner. **"Domestic Partner"** means a person of the same or opposite sex of the Insured who:

1) shares the Insured's primary residence;
2) has resided with the Insured for at least 12 months prior to the date of enrollment and is expected to reside with the Insured indefinitely;
3) is financially interdependent with the Insured in each of the following ways;
   a. by holding one or more credit or bank accounts, including a checking account, as joint owners;
   b. by owning or leasing their permanent residence as joint tenants;

c. by naming, or being named by the other as a beneficiary of life insurance or under a will;
d. by each agreeing in writing to assume financial responsibility for the welfare of the other.

4) has signed a Domestic Partner declaration with Insured, if recognized by the laws of the state in which he or she resides with the Insured;
5) has not signed a Domestic Partner declaration with any other person within the last 12 months.
6) is 18 years of age or older;
7) is not currently married to another person;
8) is not in a position as a blood relative that would prohibit marriage.

"Doctor" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

"Enrollment Period" means the period agreed upon by the Participating Organization and Us when an Eligible Person may enroll for coverage or a Covered Person may change benefit elections under the Policy.

"Hospital" means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provide organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6) is not a place for drug addicts, alcoholics, or the aged.

We will not deny a claim for services rendered in any Hospital solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by:
1. the Joint Commission on the Accreditation of Hospitals; or
2. the American Osteopathic Association; or
3. the Commission on the Accreditation of Rehabilitative Facilities.

"Hospital Confined" means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

"Immediate Family" means a Covered Person's parent, grandparent, spouse, child, brother, sister or in-laws.

"Injury" means any bodily harm sustained by a Covered Person from a Covered Accident which is the direct cause, independent of disease or bodily infirmity, of the covered loss. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

"Insured" means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a Dependent covered under the Policy.

"Life Status Change" means an event recognized by the Participating Organization and Us that qualifies the Insured to make changes in coverage at a time other than an Enrollment Period. The following events are all considered Life Status Changes:
1. marriage;

2. divorce, annulment or legal separation;
3. birth or adoption of a child;
4. change in a Dependent child's eligibility;
5. death of a spouse;
6. a change in the benefit plan or employment status of the Covered Person's spouse that affects either person's eligibility for benefits.

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

"Medically Necessary" means a treatment, service or supply that is: 1) required to treat an Injury or Sickness; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by the Covered Person's condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) eye glass frames or lenses; 6) hearing aids; 7) swimming pools or supplies for them; and 8) general exercise equipment are not Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used.

"Plan Year" means a consecutive 12-month period during which a Covered Person's insurance is in force. The first Plan Year begins on the effective date of the Covered Person's insurance under the Policy and ends after 12 consecutive months. Dependents will have the same Plan Year as the Insured.

"Sickness" means an illness, disease or condition of the Insured that causes a loss for which an Insured incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"We", "Our", "Us" means the insurance company underwriting this insurance or its authorized agent.

ELIGIBILITY FOR INSURANCE

Each person in one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

An Insured's Dependent is eligible on the latest of the date:
1. the Insured is eligible, if the Insured has Dependents on that date; or
2. the date the person becomes a Dependent.

A person who is in one of the Classes of Eligible Persons and who is also eligible as a Dependent may be insured only once under the Policy. In no event will a Dependent be eligible if the Insured is not eligible.

ENROLLMENT: The Insured and his or her Dependents may enroll for coverage within 31 days of becoming eligible for coverage through his or her employer, during the employer's open enrollment period or, within 31 days of a Life Status Change.

EFFECTIVE DATE OF INSURANCE

Insurance for an Eligible Person who is required to contribute to the cost of this insurance or insurance for an Insured's Dependent who enrolls during the enrollment period or within 31 days after he or she becomes eligible or within 31 days after a Life Status Change becomes effective on the latest of the following dates:
1. the Policy Effective Date;
2. the date We receive the completed enrollment form;
3. the date the first payroll deduction is authorized for this insurance; or
4. the first day of the Plan Year.

Newborn and Adopted Children

Insurance for any newborn Dependent child automatically becomes effective from the moment of birth. Insurance for that Dependent child automatically ends 31 days later unless the Covered Person has other Dependent children insured under the Policy or within 31 days, makes a request to continue coverage for that child and pays the required premium, when due.

An adopted child of the Covered Person will be covered on the same basis as a newborn child from the date of placement for the purpose of adoption. Coverage continues unless the placement is disrupted and the child is removed from placement.

Deferred Effective Date

If an Eligible Person or Dependent is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service. A Dependent's insurance will not be in effect prior to the date an Eligible Person is insured.

TERMINATION DATE OF INSURANCE

An Insured's coverage will end on the date:
1. the Policy terminates;
2. the Insured is no longer eligible;
3. the Insured is no longer in Active Service; or
4. the period ends for which premium is paid.

A Dependent's coverage will end on the earliest of the date:
1. he or she is no longer a Dependent;
2. the Insured's coverage ends; or
3. the period ends for which premium is paid.

Termination of insurance of any Covered Person will be without prejudice to any Covered Loss or Covered Expense incurred before the date of termination.

CONTINUATION OF INSURANCE

If the Insured's Active Service ends due to a temporary layoff, an Employer approved unpaid leave of absence, an Employer approved family medical leave or Total Disability, insurance for an Insured and his or her covered Dependents will continue, if the required premium is paid, until the earliest of the following dates:
1. the six month period following the Insured's last day of work; or
2. the date the Insured fails to return to work as required by his or her Employer; or
3. the date the Insured is no longer eligible; or
4. for a covered Dependent, the date the Dependent is no longer eligible.

"Temporary layoff" includes any period during which the employee remains employed, but is not actively working and premiums for this insurance are no longer being paid.

Any change in benefits that occurs during a period of continuation will apply on the date the Insured returns to Active Service.

REINSTATEMENT OF INSURANCE

If an Insured's insurance ends because he or she is no longer in Active Service, insurance may be reinstated for an Insured and his or her Dependents within 31 days of his or her return to Active Service.

The following conditions must be met for insurance to be reinstated:
1. the Policy remains in force;
2. the Insured and his or her Dependents are eligible under the Policy;
3. a written request for reinstatement is made; and
4. the required premium is paid.

Any benefits paid during the Plan Year in which the Insured's and his or her Dependents' insurance is reinstated will be applied towards the benefit maximums for that Plan Year.

Reinstated insurance will be effective on the later of the date the Insured returns to Active Service or the date the required premium and new enrollment form are received by Us. We will not pay benefits while insurance is not in force under the Policy.

DESCRIPTION OF BENEFITS

Below are the Provisions of the Policy. The Schedule of Benefits will govern the specific benefits available under the Policy.

DAILY HOSPITAL CONFINEMENT BENEFIT (including the Intensive Care Unit Benefit)

We will pay the Daily Hospital Confinement Benefit shown in the *Schedule of Benefits* if a Covered Person is Hospital Confined and all of the following conditions are met:

1. the Hospital stay is Medically Necessary and the direct result, from no other causes, of Injuries or illness sustained in a Covered Accident or Sickness; and
2. for a Covered Accident, the Hospital stay begins within seven (7) days of a Covered Accident.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit for this benefit is payable; or
4. the date insurance under this Policy ends.

EMERGENCY ROOM VISITS (SICKNESS ONLY)

We will pay the benefit shown in the *Schedule of Benefits* for Emergency Room Visits if a Covered Person requires Hospital emergency room treatment or services for a Medical Emergency. Covered services include the attending Doctor's charges, X-rays, laboratory procedures, use of the emergency room and supplies.

SURGERY AND ANESTHESIA BENEFIT (OUTPATIENT ONLY)

We will pay the Surgery and Anesthesia Benefit shown in the *Schedule of Benefits* if a Covered Person is ordered by a Doctor to undergo Medically Necessary Surgery as the result of a Covered Injury or Sickness.

"Surgery" means the treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including the usual aftercare for such procedure, that is:

1. necessary for treatment of the Covered Person; and
2. performed in a Hospital or an ambulatory surgical center on an Outpatient basis.

Outpatient Surgery must be performed in the outpatient department of a Hospital or an ambulatory surgical center. Ambulatory Surgical Center means a free standing facility providing ambulatory surgical or medical treatment other than a hospital, clinic or physician's office. It must be qualified to provide the treatment under the standards set by the state in which it is located.

We will pay for anesthesia services for pre-operative screening and administration of anesthesia during a surgical procedure on an outpatient basis.

EXCLUSIONS

We will not pay benefits for any loss or Injury that is caused by, or results from:

1. intentionally self-inflicted Injury.
2. suicide or attempted suicide.
3. war or any act of war, whether declared or not.
4. active duty service in the military, naval or air service of any country or international organization.
5. piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
6. Injuries or loss that happens while the Covered Person is committing or attempting to commit, a felony.
7. commission of or active participation in a riot, or insurrection.
8. bungee-cord jumping, parachuting, skydiving, parasailing, hang gliding;
9. travel in or on any on-road and off-road motorized vehicle not requiring licensing as a motor vehicle.
10. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, except while participating in Driver's Education Program.
11. travel in any aircraft owned, leased or controlled by the Participating Organization, if used as the Policyholder wishes for more than ten (10) straight days, or for more than fifteen (15) days in any year.
12. Injuries or losses that happen while the Covered Person is legally intoxicated (as determined according to the laws of the jurisdiction in which the Injury occurred), or while under the influence of any drug unless administered under the advice and consent of a Doctor.
13. repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration.
14. cosmetic surgery, except for reconstructive surgery needed as the result of an Injury or Sickness.
15. Experimental or Investigational drugs, services, supplies or any procedure held to be Experimental or Investigatory by the Company at the time the procedure is done. For the purposes of this exclusion, “Experimental or Investigational” means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The covered service will also be considered Experimental or Investigational if the Covered Person is required to sign a consent form that indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, that is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental or Investigational. A drug, device or biological product is considered Experimental or Investigational if it does not have FDA approval or approval under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption.
16. Injury to a Covered Person resulting from that Covered Person’s willful violation of the Participating Organization’s rules or regulations. Willful violation includes, but is not limited to:
    a. working without protective clothing, helmets, gloves, etc., that are required by the Participating Organization’s rules or regulations.
    b. competing in a racing vehicle that is in violation of the Participating Organization’s rules or regulations.
17. pregnancy or childbirth unless conception occurred while coverage was in force under the Policy.
18. Elective Abortion. Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
19. mental and nervous disorders (except as provided in the Policy).

20. treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
21. sexual reassignment surgery, sexual transformation surgery, sexual transgendering surgery.
22. services related to sterilization, reversal of a vasectomy or tubal ligation; in vitro fertilization and diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered Injury or Sickness.
23. treatment or services provided by a private duty nurse, unless provided for in the Policy.
24. organ or tissue transplants and related services.
25. personal comfort or convenience items.
26. rest or custodial cures.
27. hearing aids.
28. radial keratotomy.
29. treatment by a family member or member of the Covered Person's household.
30. routine dental care and treatment, except for treatment of Injury as specified in the Policy.

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

CLAIM PROVISIONS

Notice of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by the Policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number.

Claim Forms: Upon receiving written notice of claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

Proof of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required.

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

Time Payment of Claims: Any benefits due will be paid when We receive written (or authorized electronic or telephonic) proof of loss.

Payment of Claims: If the Insured dies, any Accidental Death Benefits unpaid at the time of the Insured's death will be paid to the beneficiary Our records indicate the Insured designated for these plan benefits.

If there is no named beneficiary or surviving beneficiary on record with Us or Our authorized agent, We pay these benefits in equal shares to the first surviving class of the following:
1. Spouse;

2. Children;
3. Parents;
4. Brothers and sisters

If there are no survivors in any of these classes, We will pay the Insured's estate.

If the covered Dependent dies, any Accidental Death Benefits unpaid at the time of his or her death will be paid to the Insured.

If the Insured is dismembered, Accidental Dismemberment Benefits will be paid to the Insured. If the covered Dependent is dismembered, Accidental Dismemberment Benefits will be paid to the covered Dependent.

If the Insured is: (1) a minor; or (2) in Our opinion unable to give a valid release because of incompetence, We may pay any amount due to a parent, guardian, or other person actually supporting him or her. Any payment made in good faith will end Our liability to the extent of the payment.

Beneficiary: The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. A beneficiary has no interest in the policy other than to receive the benefits for loss of life. The Insured may change the beneficiary at any time unless his or her interest has been assigned. Unless there has been an assignment, consent to change by a prior beneficiary is not needed.

The name of the beneficiary is not effective until entered on the records of the Participating Organization. We are not responsible for the correctness of the records.

If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

The Insured is the beneficiary for any covered Dependent.

All benefit payments under this Policy will be made in the United States of America in the currency of the United States of America.

Physical Examinations and Autopsy: We have the right to have a Doctor of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy before 60 days following the date proof of loss was given to Us. No such action can be brought after expiration of the applicable statute of limitations from the time written proof of loss is required to be furnished.

Recovery of Overpayment: If benefits are overpaid or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods.

1. A request for lump sum payment of the amount overpaid, or paid in error.
2. Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

ADMINISTRATIVE PROVISIONS

Premiums: The premiums for this Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

Changes in Premium Rates: We may change the premium rates from time to time with at least 31 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

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

GENERAL PROVISIONS

Entire Contract; Changes: The Policy (including any endorsements or amendments), the signed application of the Policyholder, Participating Organization, and any individual applications of Covered Persons, are the entire contract. Any statements made by the Policyholder, Participating Organization or Covered Persons will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

Clerical Error: If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms.

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

Conformity with State Laws: On the effective date of this Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws.

Not in Lieu of Workers' Compensation: This Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.