

Group Indemnity Certificate of Insurance

POLICYHOLDER: Southwest Airlines Co.

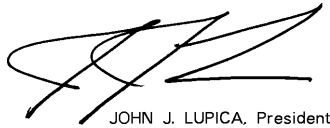
POLICY NUMBER: HIP N04855772

This Certificate of Insurance is issued under the terms of the Policy issued to the Policyholder. 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



Brandon Peene, 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 a pilot of the Policyholder who is in Active Service.

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

Maximum Benefit Amount

Daily Hospital Confinement	\$1,500 for first day confined up to 3 days per Plan Year \$250 per day for days 2-30 confined per Plan Year, up to a maximum of 29 days per Plan Year
Daily Intensive Care Unit:	Additional \$1,500 for first day confined, up to a maximum of 1 day per Plan Year Additional \$250 per day for days 2-30 confined per Plan Year up to a maximum of 29 days per Plan Year

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 Policyholder, 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 unmarried child, from the moment of birth to age 26. A child, for eligibility purposes, includes an Insured’s:

1. natural child
2. stepchild
3. adopted child (a child is considered adopted from the moment the Insured is party in a suit to adopt the child).
4. grandchild who is dependent on the Insured for federal income tax purposes at the time application for coverage of the child is made.

Insurance will continue for any child who reaches age 26 who is (1) unable to engage in any substantial gainful activity because of a mental or physical handicap and (2) is chiefly dependent on the insured for support and maintenance. The insured must send us satisfactory proof of the handicap within 31 days of the child reaching the maximum age for insurance to continue. We may require further proof at any time after that. We may not require this more often than annually after two years.

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 Policyholder 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 Policyholder 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

An Eligible Person will be insured on the later of Policy Effective Date, the first day of the month following the date he or she is eligible, or the first day of the Plan Year, if not required to contribute to the cost of this 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 twelve 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.

HOSPITAL CONFINEMENT 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 the direct result, from no other causes, of Injuries or illness sustained in a Covered Accident or Sickness.
2. The Hospital stay begins within 7 days of a Covered Accident or Sickness and lasts for at least 24 consecutive hours.

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;
4. the date insurance under the Policy ends.

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. Injuries or loss that happens while the Covered Person is committing or attempting to commit, a felony.
6. travel in or on any on-road and off-road motorized vehicle not requiring licensing as a motor vehicle.
7. 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.
8. 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.
9. cosmetic surgery, except for reconstructive surgery needed as the result of an Injury or Sickness.
10. 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.

11. 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.
12. sexual reassignment surgery, sexual transformation surgery, sexual transgendering surgery.
13. treatment by a family member or member of the Covered Person's household.
14. work-related injuries or injuries covered under Workers' Compensation, Employer's Liability Laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
15. treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications of those procedures.

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 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.

All benefits will be paid within 60 days after We receive satisfactory proof of loss.

The Policy will pay benefits of a Dependent child to a person who is not covered under the Policy if the following conditions are met:

1. a certified copy of the court order providing for the managing or possessory conservator of the child issued by a court of competent jurisdiction in Texas or any other state is submitted to Us.
2. a written notice that the person is the managing or possessory conservator of the child is submitted to Us.

We are required to pay benefits to The Texas Department of Human Services in certain situations shown below. In these situations, this method of benefit payment replaces any description of benefit payment shown in the Policy.

All benefits paid on behalf of a Dependent child must be paid directly to The Texas Department of Human Services under the following conditions:

1. The Texas Department of Human Services is paying the benefits for the Dependent child; and
2. The Covered Person has legal custody of the Dependent child or the Covered Person does not have legal custody of the Dependent child but is required to pay child support.

A notice must be attached to Our claim department form to the claim form and submit both forms to Us. Payment will be made to The Texas Department of Human Services if it has paid for any covered expenses through Medicaid.

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 Policyholder. 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 and any individual applications of Covered Persons, are

the entire contract. Any statements made by the Policyholder 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 Policyholder, 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.

IMPORTANT NOTICE

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose our right to appeal

CHUBB

To get information or file a complaint with your insurance company or HMO:

Call: Customer Service at **1-800-36-CHUBB**

Toll-free: CHUBB at **1-800-36-CHUBB**

Email: ChubbUSCustomerServices@chubb.com

Mail: 202B Hall's Mill Road, Whitehouse Station, NJ 08889

The Texas Department of Insurance

To get help with and insurance question or file a complaint with the state:

Call with a question: **1-800-252-3439**

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC CO-CP, P.O. Box 12030, Austin, TX 78711-2030

AVISO IMPORTANTE

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.:

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

CHUBB

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Servicio al Cliente al **1-800-36-CHUBB**

Teléfono gratuito: **1-800-36-CHUBB**

Correo electrónico:
ChubbUSCustomerServices@chubb.com

Dirección postal: 202B Hall's Mill Road, Whitehouse Station, NJ 08889

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC: CO-CP , P.O. Box 12030, Austin, TX 78711-2030

CHUBB GROUP U.S. PRIVACY NOTICE

FACTS	WHAT DOES CHUBB GROUP DO WITH YOUR PERSONAL INFORMATION?
Why?	Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state 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.
What?	<p>The types of personal information we collect and share depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none"> ▪ Social Security number and payment history ▪ insurance claim history and medical information ▪ account transactions and credit scores <p>When you are no longer our customer, we continue to share information about you as described in this notice.</p>
How?	All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons the Chubb Group chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Chubb 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, 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 our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	Call 1-800-258-2930 or go to www.chubb.com/us-en/privacy.aspx
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Who we are

Who is providing this notice?

The Chubb Group. A list of these companies is located at the end of this document.

What we do

How does Chubb Group 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 personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations.

How does Chubb Group 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 provide account information
- give us your contact 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 those with a Chubb name and financial companies, such as Westchester Fire Insurance Company and Great Northern Insurance Company.

Nonaffiliates

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

- Chubb 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 categories of companies such as banks.

Other important information

For Insurance Customers in AZ, CA, CT, GA, IL, MA, ME, MN, MT, NV, NC, NJ, OH, OR, and VA only: Under state law, under certain circumstances, you have the right to see the personal information about you that we have on file. To see your information, write Chubb Group, Attention: Privacy Inquiries, 202 Hall's Mill Road, P.O. Box 1600, Whitehouse Station, NJ 08889-1600. Chubb may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is not accurate, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For Nevada residents only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling 1-800-258-2930, emailing us at privacyinquiries@Chubb.com, or writing to Chubb Group, Attention: Privacy Inquiries, 202 Hall's Mill Road, P.O. Box 1600, Whitehouse Station, NJ 08889-1600. You are being provided this notice under Nevada state law. In addition to contacting Chubb, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

For Vermont residents only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

Chubb Group Companies Providing This Notice

This notice is being provided by the following Chubb Group companies to their customers located in the United States: ACE American Insurance Company, ACE Capital Title Reinsurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Life Insurance Company, ACE Property and Casualty Insurance Company, Agri General Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Insurance Company, Century Indemnity Company, Chubb Custom Insurance Company, Chubb Indemnity Insurance Company, Chubb Insurance Company of New Jersey, Chubb Lloyds Insurance Company of Texas, Chubb National Insurance Company, Executive Risk Indemnity Inc., Executive Risk Specialty Insurance Company, Federal Insurance Company, Great Northern Insurance Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Pacific Indemnity Company, Penn Millers Insurance Company, Vigilant Insurance Company, Westchester Fire Insurance Company and Westchester Surplus Lines Insurance Company.

Chubb Group

Notice of HIPAA Privacy Practices for Protected Health Information

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

This notice is effective as of November 2, 2023.

The Chubb Group of Companies, as affiliated covered and hybrid entities, (the "Company") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information, and to inform you about:

- The Company's uses and disclosures of Protected Health Information ("PHI");
- Your privacy rights with respect to your PHI;
- The Company's duties with respect to your PHI;
- Your right to file a complaint with the Company and to the Secretary of the U.S. Department of Health and Human Services ("Secretary of Health and Human Services" or "HHS"); and
- The person or office to contact for further information regarding the Company's privacy practices.

PHI includes all individually identifiable health information transmitted or maintained by the Company, regardless of form (e.g., oral, written, electronic).

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), regulates PHI use and disclosure by the Company. You may find these rules at *45 Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

I. Notice of PHI Uses and Disclosures

A. Required Uses and Disclosures

Upon your request, the Company is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of Health and Human Services to investigate or determine the Company's compliance with the privacy regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Company and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Company may also disclose PHI to a plan sponsor for purposes related to treatment, payment and health care operations and as otherwise permitted under HIPAA to the extent the plan documents restrict the use and disclosure of PHI as required by HIPAA.

Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Company may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including establishing employee contributions, claims management, obtaining payment under a contract of reinsurance,

utilization review and pre-authorizations). For example, the Company may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Company.

Health care operations include, but are not limited to, underwriting, premium rating and other insurance activities relating to creating or reviewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Company may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions. The Company will not use or disclose PHI that is genetic information for underwriting purposes.

The Company also may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

C. Uses and Disclosures that Require Your Written Authorization

The Company will not use or disclose your PHI for the following purposes without your specific, written authorization:

- Use and disclosure of psychotherapy notes, except for your treatment, Company training programs, or to defend the Company against litigation filed by you.
- Use and disclosure for marketing purposes, except for face to face communications with you.
- Use and disclosure that constitute the sale of your PHI. The Company does not sell the PHI of its customers.

Except as otherwise indicated in this notice, uses and disclosures of PHI will be made only with your written authorization subject to your right to revoke such authorization. You may revoke an authorization by submitting a written revocation to the Company at any time. If you revoke your authorization, the Company will no longer use or disclose your PHI under the authorization. However, any use or disclosure made in reliance of your authorization before its revocation will not be affected.

D. Uses and Disclosures Requiring Authorizations or Opportunity to Agree or Disagree Prior to the Use or Release

If you authorize in writing the Company to use or disclose your own PHI, the Company may proceed with such use or disclosure without meeting any other requirements and the use or disclosure shall be consistent with the authorization.

Disclosure of your PHI to family members, other relatives or your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

Use and disclosure of your PHI is allowed without your authorization or request under the following circumstances:

- (1) When required by law.
- (2) When permitted for purposes of public health activities, including when necessary to report product defects, permit product recalls and conduct post-market surveillance. PHI may also be used or disclosed if you may have been exposed to a communicable disease or are at risk of contracting or spreading a

disease or condition, if authorized by law.

- (3) When authorized by law to report information about abuse, neglect or domestic violence. In such case, the Company will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law where the parents or other representatives may not be given access to the minor's PHI.
- (4) The Company may disclose your PHI to a health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- (5) The Company may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Company that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or all objections were resolved in favor of disclosure by the court or tribunal.
- (6) When required for law enforcement purposes (for example, to report certain types of wounds).
- (7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Company is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Company's best judgment.
- (8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. The Company may also disclose your PHI to organ procurement organizations.
- (9) The Company may use or disclose PHI for government-approved research, subject to conditions.
- (10) When consistent with applicable law and standards of ethical conduct if the Company, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- (11) For certain government functions such as related to military service or national security.
- (12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- (13) That is "incident to" an otherwise permitted use or disclosure of PHI by the Company.

II. Rights of Individuals

A. Right to Request Restrictions on Use and Disclosure of PHI

You may request the Company to restrict its use and disclosure of your PHI to carry out treatment, payment or health care operations, or to restrict its use and disclosure to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Company may not be required to agree to your request, unless you have paid out of pocket in full for services, depending on the specific facts.

The Company will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations, such as a location other than your home. The Company will accommodate this request if you state in writing that you would be in danger from receiving communications through the normal means.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the Company by writing to North America Chief Privacy Officer, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, calling 1-833-324-9798, or emailing naprivacyoffice@chubb.com.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Company maintains the PHI.

"*Protected Health Information*" (PHI) includes all individually identifiable health information transmitted or maintained by the Company, regardless of form.

"*Designated Record Set*" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Company is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made by writing to North America Chief Privacy Officer, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, calling 1-833-324-9798, or emailing naprivacyoffice@chubb.com.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Company amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Company has 60 days after the request to act on the request. A single 30-day extension is allowed if the

Company is unable to comply with the deadline. If the request is denied in whole or part, the Company must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made by writing to North America Chief Privacy Officer, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, calling 1-833-324-9798, or emailing naprivacyoffice@chubb.com.

You or your personal representative(s) will be required to complete a form to request amendment of the PHI in your designated record set.

D. Right to Receive an Accounting of PHI Uses and Disclosures

Upon your request, the Company will provide you with an accounting of disclosures by the Company of your PHI during the six (6) years prior to the date of your request. However, such accounting need not include PHI disclosures made to carry out treatment, payment or health care operations, and certain other disclosures such as (1) to individuals about their own PHI; (2) prior to the compliance date; or (3) based upon your own written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Company will charge a reasonable, cost-based fee for each subsequent accounting.

E. Right to Obtain a Paper Copy of This Notice Upon Request (even if you have consented to receive this notice electronically)

To obtain a paper copy of this notice contact: North America Chief Privacy Officer, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone 1-833-324-9798, or email naprivacyoffice@chubb.com.

F. Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Company retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

III. **The Company's Duties**

The Company is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices and to notify affected individuals of a breach of unsecured PHI. The Company is required to abide by the terms of this notice.

The Company reserves the right to change its privacy practices and to apply the changes to any PHI received or

maintained by the Company prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Company still maintains PHI. This notice and any revised version of this notice will be posted on the Company's internal website or mailed.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Company or other privacy practices stated in this notice.

A. "Minimum Necessary" Standard

When using or disclosing PHI, or when requesting PHI from another covered entity, the Company will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Company's compliance with legal regulations.

This notice does not apply to information that has been "de-identified." *De-identified information* is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. *De-identified information* is not individually identifiable health information.

In addition, the Company may use or disclose "summary health information" to a plan sponsor for obtaining premium bids or modifying, amending or terminating coverage under a group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the plan sponsor has provided health benefits under the group health plan; and from which identifying information has been deleted in accordance with HIPAA.

IV. Your Right to File a Complaint with the Company or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Company by writing to North America Chief Privacy Officer, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, calling 1-833-324-9798, or emailing naprivacyoffice@chubb.com.

You may file a complaint with the U.S. Department of Health and Human Services by sending a written complaint to Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201, emailing OCRComplaint@hhs.gov, faxing (202) 619-3818, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.

Your complaint must be submitted within 180 days of when you believe the violation occurred. The Company will not retaliate against you for filing a complaint.

V. Contact Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact: North America Chief Privacy Officer, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone 1-833-324-9798, or email naprivacyoffice@chubb.com.

VI. Chubb Group Legal Entities

This following is a list of the Chubb Group of Companies located in the United States: ACE American Insurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Life Insurance Company, ACE Property and Casualty Insurance Company, Agri General Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Insurance Company, Century Indemnity Company, Chubb Custom Insurance Company, Chubb Indemnity Insurance Company, Chubb Insurance Company of New Jersey, Chubb Lloyds Insurance Company of Texas, Chubb National Insurance Company, Executive Risk Indemnity Inc., Executive Risk Specialty Insurance Company, Federal Insurance Company, Great Northern Insurance Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Pacific Indemnity Company, Penn Millers Insurance Company, Vigilant Insurance Company, Westchester Fire Insurance Company, Westchester Surplus Lines Insurance Company, Combined Insurance Company of America, and Combined Life Insurance Company of New York. These companies have designated themselves as *hybrid entities* and only those designated health care components identified by such companies are subject to HIPAA. In addition, these companies are legally separate affiliated companies under common ownership and have designated themselves as a *single covered entity* for purposes of HIPAA compliance.