SCHEDULE

POLICY NO.: SR2014DC-P-050467

POLICYHOLDER INFORMATION:

League of American Wheelmen dba League of American Bicyclists
1612 K Street NW, Suite 1102
Washington, DC 20006

Effective Date: February 1, 2021 **Expiration Date:** February 1, 2022

ELIGIBILITY:

Class 1a: All members of registered Policyholder Bicycle Clubs participating in bicycle rides, time trials and walking activities conducted and supervised by a Policyholder Club. Invited guests are also covered for their first bicycle ride, time trial or walking activity conducted and supervised by a Policyholder Club. A fee cannot be charged unless the bicycle ride, time trial or walking activity is open exclusively to members of the Bicycle Club.

Class 1b: All members of registered Policyholder Bicycle Clubs participating in the on-bicycle component of a bicycle course that is open only to members of the registered Policyholder Bicycle Club (whether or not such course meets the definition of Bicycle Education Course).

Class 2: All registered participants including volunteers of Special Events. Special Events include non-competitive walking, any bicycle ride or time trial conducted and supervised by a Policyholder Bicycle Club or Advocacy Organization:

a) for which a fee is charged and the appropriate premium has been paid; or
b) for which the participants are not covered under Class 1a, Class 2a, or Class 4, but for which the Bicycle Club or Advocacy Organization has elected to add coverage, and for which the appropriate premium has been paid.

Note: Member participants in a bicycle ride conducted and supervised by a Bicycle Club where a fee is charged, but that is open exclusively to members, will be covered under Class 1a.

Volunteers will be covered for set-up and tear-down one day before the event and one day after the event, if applicable. All Special Events must be on file with American Specialty Insurance & Risk Services, Inc. prior to the event.

Class 3: All registered participants of League-conducted LCI seminars on bike training and safety.

Class 4: All members of registered Policyholder Advocacy Organizations participating in bicycle rides and time trials conducted and supervised by a Policyholder Advocacy Organization. Invited guests are also covered for their first bicycle ride or time trial conducted and supervised by a Policyholder Advocacy Organization. A fee cannot be charged.

For the purposes of this Class: “Registered Policyholder Advocacy Organizations” means only those Advocacy Organizations who opted to buy coverage for regular club rides at the time of enrollment and confirmed that they conduct 26 or fewer rides consisting of 50 or fewer bicycle riders on average.

Class 5: All attendees of Bicycle Education Courses organized by a registered Policyholder Bicycle Club or Policyholder Advocacy Organization. Insureds are covered only if injured during the portion of the course that involves on-bike activities.

a) League Cycling Instructors are the instructors for ALL courses.
b) Courses taught by instructors other than League Cycling Instructors.

100% Participation is required for all Classes.

For purposes of this policy/coverage:

a) Bicycle Education Course means a program of instruction focused on bicycle safety and related topics in which the attendees sign up, enroll, or register by name.
b) A time trial is an individual timing activity. Time trials involving racing between individuals are not covered under this policy.
c) Coverage does not apply to racing. Racing means an activity in which individuals are engaged in direct speed competition with other bicycle riders. An activity that includes a timing element, such as a designated time for completion or an individual being timed for personal best does not, in itself, constitute racing.

COVERED ACTIVITIES: All activities will be submitted on a monthly basis and kept on file with Us.

SCOPE OF COVERAGE:

Class	**Insured Risk**	**Benefits**
ALL	Activity Coverage (IRACT062)	AD&D (ADSL3PLEG001) AME (AME002)

BENEFITS:

Accidental Death & Specific Loss (ADSL3PLEG001)

Principal Sum Amount	$5,000.00
Loss Period	Loss within 365 Days of Injury

Paralysis Benefit

Hemiplegia	25% of Principal Sum
Paraplegia	25% of Principal Sum
Quadriplegia	50% of Principal Sum
Loss Period	Within 365 days after the date of the accident and continuing for one year

Medical Expense for Accident (AME002) - Full Excess (TBFE004/TBFIFTY002)

Maximum Benefit Amount*	$10,000.00 per Injury
Benefit Percentage	100% of Allowable Expense
Deductible (Reducing)	$500.00 per Injury
Loss Period	Initial treatment received within 90 days of Injury
Benefit Period	Benefits payable for 52 weeks from accident date

Artificial Limbs, Eyes and Larynx
(Does not include repair and replacement of existing items)

Benefit Amount	Subject to the Medical Expense Benefit & Deductible

*Failure by an Insured to follow the terms and conditions of his or her primary coverage will result in a benefit reduction of eligible expenses to 50% of the amount otherwise payable.

The following riders are attached to and made a part of this policy:

Physical Therapy Practice Amendment Rider	00W3M Rev.
Guaranty Association Act Notice	M20812_1014

PREMIUM:

Class 1: Club Activities	
For the first 1,000 members	$2.43 per Member
For the second 1,000 members	$2.05 per Member
Clubs with more than 2,000 members	$1.51 per Member
Minimum Premium per Club	$100.00 per Club
A Discount applies to Club coverage only:	
February - July	Full Premium
August and September	25% Discount
October - December	50% Discount
January	75% Discount
Class 2a or 2b: Special Events	
For the first 1,000 riders or walking participants	$2.43 per Rider/Walker
For the second 1,000 riders or walking participants	$1.94 per Rider/Walker
For each rider or walking participant in excess of 2,000	$1.40 per Rider/Walker
Minimum Premium per Event	$100.00 per Event
Class 3: LCI Seminars	
Flat Annual Premium	$ Annual
(Premiums are based on 40 courses per Year, with an average of 10-15 persons per Class.)	
Class 4: Advocacy Organizations	
Flat Annual Premium	$102.00 per Organization
(Premiums are based on 26 or fewer rides, with 50 or fewer average riders).	
Class 5: Education Classes	
Class 5 (a) – Premium per Club	$88.00 per Club
Class 5 (b) – Premium per Club	$118.00 per Club

This plan has a non-refundable minimum premium of $1,000.00 per policy year, which is fully earned on the date the coverage goes into effect.

012721:bdt

Mutual of Omaha

3300 Mutual of Omaha Plaza
Omaha, NE 68175

This policy is issued to League of American Wheelmen dba League of American Bicyclists ("the Policyholder").

This policy is a legal contract between the Policyholder and Us. It is issued in consideration of payment of premiums.

This policy is issued in and will be interpreted by the laws of the State of District of Columbia, without giving effect to the principles of conflicts of law of that State or any other state. Any part of this policy which is in conflict with the laws of the State of District of Columbia is changed to conform to the minimum requirements of that State's laws.

We agree to pay benefits subject to the terms, conditions, and limitations of this policy.

EFFECTIVE DATE AND POLICY TERM

This policy takes effect on February 1, 2021 (the Policy Effective Date) at the Policyholder's main office. It expires on February 1, 2022.

POLICY NUMBER: SR2014DC-P-050467

THIS IS A BLANKET LIMITED ACCIDENT POLICY.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

LIMITED BENEFIT. PLEASE READ CAREFULLY.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.

James T. Blackledge

Chief Executive Officer

Daya Vankat

Corporate Secretary

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INSURED RISKS

Unless otherwise stated in the Schedule, We will pay benefits for a loss only once.

ACTIVITY COVERAGE (IRACT062)

We will pay the benefits in this policy for an Insured while:

- participating in a Sponsored and Supervised Activity;
- traveling as part of a group in transportation authorized or arranged by the Policyholder.

ELIGIBILITY FOR BENEFITS

ELIGIBILITY

Persons who are eligible to be an Insured under this policy are described in the Schedule. This includes persons who may become eligible while this policy is in force.

WHEN INSURANCE BEGINS

Insurance for an Insured begins on the later of:

- the Policy Effective Date; or
- the day the Insured becomes eligible under the terms of this policy.

CHANGE IN COVERAGE

Any change in the Insured's coverage because of change of class as shown in the Schedule will become effective on the date of the change.

WHEN INSURANCE ENDS

Insurance for an Insured will end on the earliest of the date:

- the Insured is no longer eligible;
- the Insured enters full time active duty in any Armed Forces;
- any premium for the Insured is due and unpaid, subject to the Grace Period provision; or
- this policy is terminated.

Termination of insurance will not affect a claim incurred while coverage was in effect.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFIT (ADSL3PLEG001)

If an Insured suffers a loss listed below from an Accident within the Loss Period stated in the Schedule, We will pay the benefit opposite the Loss. If the Insured sustains more than one loss as the result of one Accident, We will pay only the largest benefit to which the Insured is entitled.

The Principal Sum is shown in the Schedule.

TABLE OF BENEFITS FOR ACCIDENTAL DEATH AND SPECIFIC LOSS

Loss	*Benefit Amount*
Loss of Life	100% of Principal Sum
Loss of Both Hands	100% of Principal Sum
Loss of Both Feet	100% of Principal Sum
Loss of Entire Sight of Both Eyes	100% of Principal Sum
Loss of One Hand and One Foot	100% of Principal Sum
Loss of One Hand and Entire Sight of One Eye	100% of Principal Sum
Loss of One Foot and Entire Sight of One Eye	100% of Principal Sum
Loss of Speech and Hearing	100% of Principal Sum
Loss of Entire Sight of One Eye	50% of Principal Sum
Loss of Speech or Hearing	50% of Principal Sum
Loss of One Hand or One Foot	50% of Principal Sum
Loss of Thumb and Index Finger	25% of Principal Sum
Quadriplegia (complete loss of function) of Four Limbs	50% of Principal Sum
Paraplegia (complete loss of function) of Both Lower Limbs	25% of Principal Sum
Hemiplegia (complete loss of function of one side of the body with involvement of the arm and leg)	25% of Principal Sum

MEDICAL EXPENSE FOR ACCIDENT BENEFIT (AME002)

We will pay the following Medical Expenses incurred as a result of an Accident. The Medical Expense Maximum and any applicable sub-limit amounts are shown in the Schedule.

1. Hospital room and board charges, up to the average semi-private daily room rate, for each day in the Hospital;
2. Intensive Care Unit charges are payable in lieu of payment for Hospital room and board charges for each day the Insured is confined in an intensive care unit;
3. Hospital miscellaneous charges during a hospital confinement. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take-home items, or other convenience items;
4. outpatient charges by a Hospital for:
    a. emergency room treatment. Treatment must be received within 72 hours of the Accident;
    b. emergency room physician; or
    c. use of surgical facilities;
5. surgical charges for the primary performance of a surgical procedure by a Physician; subject to the following:
    a. if bilateral or multiple surgical procedures are performed by one Physician, We will pay the Medical Expenses for the primary procedure;
    b. for each procedure that is not the primary procedure performed through the same incision as the primary procedure, we will pay 50% of the amount otherwise payable if the additional procedure were the primary procedure;
    c. if multiple surgical procedures are performed during the same operating session, reimbursement shall be based upon, 100% of Allowable Expense for the primary procedure, 50% of Allowable Expense for the secondary procedure and 25% of Allowable Expense for the third and subsequent procedures;
    d. any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental and no benefits will be provided for such procedure;
    e. if multiple unrelated surgical procedures are performed by two or more Physicians on separate operative fields, benefits will be based on the Medical Expenses for each Physician's primary procedure; and

    f. if two or more Physicians perform a procedure that is normally performed by one Physician, We will only pay the Medical Expenses for the primary Physician;
6. surgical charges for assistant surgeon duties will be reimbursed at 25% of the allowable for surgery codes that have been assigned an assistant surgery indicator by the Centers for Medicare & Medicaid Services;
7. charges for anesthesia and its administration for surgery;
8. Physician's charges for other than pre- or post-operative care for in-Hospital visits or office visits;
9. charges for, including Physician's charges for reading or interpreting the results of, Laboratory Tests and diagnostic imaging including X-Ray, MRI, or CAT Scan;
10. charges for nursing services, other than routine Hospital care, by or under the supervision of a Nurse;
11. treatment of the spine by manual or mechanical means;
12. charges for physiotherapy which includes:
    a. adjustment;
    b. diathermy;
    c. heat treatment;
    d. manipulation;
    e. microtherm;
    f. ultrasonic;
13. Ambulance Service (Surface) and Ambulance Service (Air);
14. Orthopedic Appliances and prosthetics, not including replacements;
15. Prescription Drugs;
16. dental expense for sound natural teeth; and
17. other Medical Expenses as noted in the Schedule.

EXCLUSIONS (EXCUS006A-DC)

We will not pay benefits for a loss due to or expenses incurred for:

1. intentionally self-inflicted injury, suicide while sane or insane;
2. Injury caused by, attributable to, or resulting from the Insured's Intoxication;
3. operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
4. operating a motor vehicle while having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred;
5. commitment of or an attempt to commit a felony, or engagement in an illegal activity;
6. any Injury that results from fighting, brawling, assault or battery;
7. an act of declared or undeclared war;
8. active duty service in any Armed Forces;
9. operating, learning to operate, or serving as a pilot or crew member of any aircraft unless specified in the Insured Risk section of this policy;
10. orthodontic braces or appliances;
11. any loss for which benefits are paid under state or federal worker's compensation, employers' liability, or occupational disease law;
12. a charge which is in excess of the Allowable Expense;
13. treatment of a hernia.

TERMS OF BENEFIT PAYMENTS

We will pay the benefits specified in the DESCRIPTION OF BENEFITS section to all Insureds who suffer a loss within the Scope of Coverage due to Injury.

FULL EXCESS MEDICAL EXPENSE (TBFE004/TBFIFTY002)

We will pay the Medical Expenses an Insured incurs for covered services that exceed amounts payable by any Other Insurance Plan, subject to the Deductible, Benefit Percentage, and Benefit Period shown in the Schedule. We will determine the amount of benefits provided by any Other Insurance Plan without reference to any coordination of benefits, non-duplication of benefits or similar provisions. The amount of benefits provided by an Other Insurance Plan includes any amount to which the Insured is entitled whether or not a claim is made for the benefits. This Policy is secondary to all Other Insurance Plans.

The first Medical Expense must be incurred within the Loss Period stated in the Schedule.

The Maximum Benefit Amount payable under this policy is shown in the Schedule.

If an Insured fails to follow the terms and conditions of the Insured's primary coverage, We will reduce eligible Medical Expenses to 50% of the amount We would otherwise pay. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by the Other Insurance Plan.

NON-DUPLICATION OF BENEFITS

This provision applies if an Insured:

- is covered by any Other Insurance Plan; and
- would, as a result, receive total medical expense or service benefits that would exceed the expenses actually incurred.

In this case, the Medical Expense for Accident Benefit payable under this policy will be reduced by the excess amount of benefits. The total amount of benefits payable will never exceed 100% of the Medical Expenses or service benefits.

CLAIM PROVISIONS

NOTICE OF CLAIM

We must receive written notice within 90 days after a loss occurs or begins, or as soon as reasonably possible. Notice can be given at Our home office or to Our authorized representative. Notice should include:

- the Policyholder's name;
- the policy number; and
- the Insured's name and address.

CLAIM FORMS

When We receive the notice of the claim, We will send forms for filing proof of loss within 15 days. If We do not send the necessary forms within 15 days, written information may be given that includes the nature, date, cause, and extent of the loss for which claim is made.

PROOF OF LOSS

We must be given written proof of loss at Our home office or to Our authorized representative within 90 days after the date of the loss. If the written proof is not given within 90 days, the claim will not be invalidated or reduced if:

- it was not reasonably possible to give proof within 90 days; and
- proof is given as soon as reasonably possible, but not later than one year from the date it is otherwise required, except in the absence of legal capacity.

If the claim is for a continuing loss for which this policy provides periodic payments, written proof that the loss continues must be given to Us or to Our authorized representative at the intervals We require.

Physical Examination and Autopsy

We have the right to have an Insured examined at Our cost and as often as reasonably necessary while the claim is pending. We may require an autopsy at Our expense unless prohibited by law.

PAYMENT OF CLAIMS

Benefits will be paid after We receive acceptable proof of loss and confirm benefits are payable.

We will pay benefits for loss of life and any benefits payable to the Insured but unpaid at the Insured's death to the Insured's named beneficiary for this policy. This choice must be in writing and filed with Us, or filed with the Policyholder if We have agreed in advance.

The Insured has the right to change the beneficiary. Unless this right has been given up, the Insured does not need the consent of the beneficiary to make a change.

If the Insured has not named a beneficiary or no beneficiary survives the Insured, We will pay benefits at the Insured's death as follows:

- to the Insured's surviving spouse or domestic partner or civil union partner; if none, then
- in equal shares to the Insured's surviving children; if none, then
- in equal shares to the Insured's surviving parents; if none, then
- in equal shares to the Insured's surviving brothers and sisters; if none, then
- to the Insured's estate.

If benefits are payable to a person who is not legally competent to claim or release benefits, a minor, or an estate, We may pay up to $1,000 to any relative by blood or marriage whom We find entitled to the payment. This good faith payment satisfies Our legal duty to the extent of the payment.

Assignment of Benefits

The Insured may direct that We pay benefits to a Hospital, Physician or other provider who furnished care, diagnosis, advice or supplies. We are not liable for any actions We take before We receive notice of the assignment. We are not responsible for the validity of any assignment of benefits.

OPPORTUNITY TO REQUEST AN APPEAL

The claimant may request an appeal, in writing, within 60 days after receiving notice of Our initial claim review decision.

The request for an appeal should include:

- the Policyholder's name and the Policy number or group number;
- the Insured's name and mailing address;
- the name and mailing address of the claimant filing the appeal, if different from the Insured;
- the nature of the appeal; and
- any additional information that may have been omitted from Our review or that We should consider.

By requesting an appeal, the claimant has authorized Us, or anyone We designate, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal. We will review all information submitted and make Our final determination. No additional appeals are available.

Applicable state laws may contain requirements for claims review and appeal procedures. To the extent that this provision is inconsistent with any state law requirement, the requirement that is most favorable to the claimant will apply.

PREMIUM PROVISIONS

REPORTING REQUIREMENTS

The Policyholder or its authorized agent must report to Us any additional information required, as We and the Policyholder agree. We must receive this report before the premium due date.

GRACE PERIOD

There is a 31-day grace period for payment of each premium due after the first premium. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period unless the Policyholder has notified Us of its intention to terminate this policy.

If We have not been notified otherwise and the premium has not been paid, this policy will end on the date premium was due.

CHANGES IN RATES

We have the right to change the premium rates:

- at any time there is a change in the coverage provided or classes eligible;
- at any time there is a change in the risks We have assumed; or
- after the first 12 months insurance is in effect.

New rates based on coverage or eligibility changes will take effect on the effective date of those changes. Otherwise, we will give 60 days written notice when we change the rates. Notice will be sent to the Policyholder's most recent address in Our records.

REINSTATEMENT AFTER TERMINATION

If this policy terminates for any reason, the Policyholder may request to reinstate it. We will reinstate only if:

- an authorized representative in Our home office agrees in writing to reinstate this policy;
- the Policyholder agrees in writing to accept any written conditions of reinstatement that We impose;
- all past due premiums are paid, including any premium for the time insurance was in effect during the grace period; and
- the premium due from the date of reinstatement until the next premium due date is paid.

GENERAL PROVISIONS

INSURANCE CONTRACT

The insurance contract consists of:

- this policy;
- the attached Schedule; and
- any riders or endorsements.

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change, unless required by law. No one else has the authority to change the insurance contract. A change in the insurance contract must be:

- in writing;
- made a part of this policy; and
- signed by Our authorized representative in Our home office.

WORKERS COMPENSATION INSURANCE

This policy does not satisfy any requirement for coverage under any workers compensation law.

POLICYHOLDER RECORDS

The Policyholder or its authorized administrator will maintain records of the essential features of each Insured's insurance under this policy.

We have the right to examine the Policyholder's records relating to coverage under this policy. Examination may occur at any reasonable time up to the later of:

- two years after this policy ends; or
- the date of final adjustment and settlement of all claims under this policy.

REIMBURSEMENT/SUBROGATION

Applicability

If there is a conflict between the provisions of the Reimbursement/Subrogation section of the policy and the provisions of any Other Insurance Plan, the provisions that provide the greatest rights to Us and this policy govern.

Obligations of Insured

Relating to benefits covered by this policy, an Insured must:

- immediately notify Us of any potential causes of action or claims for a recovery that the Insured may have against a third party;
- notify Us of any agreement with a third party;
- provide Us with a copy of any summons, complaint, or other process served in any lawsuit in which the Insured seeks a recovery;
- provide Us with a copy of any agreement with a third party;
- immediately notify Us of any settlement offer regarding a potential recovery or any payment made pursuant to an agreement;
- obtain written consent from Us before entering into any agreement with a third party involving a potential recovery;
- cooperate and assist Us in enforcing Our subrogation and reimbursement rights;
- provide any information as may be requested by Us related to Our subrogation and reimbursement rights;
- assist Us in any action against any third party; and
- upon Our request, execute a subrogation agreement, assignment of recoveries, and/or reimbursement agreement in Our favor.

If a third party pays the Insured directly based on an agreement, the Insured must reimburse Us the amount of any payments We previously made to the Insured (or for which We may have future responsibility) with respect to Injury covered by this policy. The Insured must hold any recovery or payment (including amounts paid for future medical expenses) and any right of recovery against the third party in trust for Us.

An Insured may not take any action to prejudice Our rights under the policy.

Our Rights

We may:

- take action against any party (including, but not limited to, an attorney or trust) in possession of property or funds awarded or paid as a result of the Insured's Injury if such property or funds should be or should have been paid to Us under this Reimbursement/Subrogation section;
- seek a temporary restraining order against any party to prevent disbursement of any property or funds to which We have a right;
- seek restitution in equity (through the imposition of a constructive trust for Our benefit) from any party for the full amount of benefits paid by Us or for which We may have future responsibility;
- invoke equitable remedies as may be necessary to enforce the terms of the policy, including, but not limited to, specific performance, restitution and the imposition of an equitable lien and/or constructive trust, as well as injunctive relief;
- refuse to pay benefits to an Insured if the Insured fails to comply with this Reimbursement/Subrogation section, fails to cooperate with Us in regard to Our subrogation and reimbursement rights, or refuses to execute and deliver any papers that We may require in furtherance of Our subrogation and reimbursement rights;
- if the Insured fails to reimburse Us as provided in this Subrogation/Reimbursement section, offset any future benefits otherwise payable to or on behalf of the Insured, until the amount required to be reimbursed under the policy is fully offset;
- if the Insured receives a third party payment relating to expenses or benefits paid or payable by the policy, suspend all further benefit payments related to the Insured until the reimbursable portion is returned to Us or offset against amounts that would otherwise be paid to or on behalf of the Insured; and
- if an Insured fails or refuses to comply with this Reimbursement/Subrogation section, terminate the Insured's coverage.

We legally succeed the Insured's right of recovery against a third party up to the amount of benefits We have paid (or for which We may have future responsibility) with respect to the Insured's Injury. We have first priority on any money recovered from the third party, including, but not limited to, any amounts paid for medical costs over the uninsured or underinsured motorist's coverage, medical malpractice or any liability plan. Our contractual right to reimbursement is in addition to and separate from equitable subrogation. Our contractual right of reimbursement may be enforced under the same terms as discussed in this Reimbursement/Subrogation section.

If the Insured is a minor, We have no obligation to pay benefits related to Injury or sickness caused by a third party until after the Insured's legal representative obtains valid court recognition and approval of Our 100%, first-dollar subrogation and reimbursement rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement of these rights.

If We file suit to enforce Our right to recover from the Insured, We reserve the right to be reimbursed for Our court costs and attorneys' fees in relation to the suit.

Priority; Other Legal Doctrines

If a third party makes any payment to the Insured, the Insured's attorney, or a trust for the Insured's benefit, the payment must first be used to provide equitable restitution to Us, to the full extent of expenses or benefits paid by or payable under the policy. Our priority applies despite other legal doctrines or theories. Our rights of subrogation and reimbursement under this Reimbursement/Subrogation section are not affected, reduced, or eliminated by the make-whole doctrine, the common fund doctrine, the doctrine of comparative fault theory, or any other legal doctrine or theory. We expressly reject the common fund doctrine with regard to attorneys' fees. Our rights are not affected, reduced, or eliminated by any allocation that purports to allocate recovery amounts in whole or in part to nonmedical damages.

POLICY TERMINATION

We may terminate this policy at any time. We will give at least 60 days notice before termination.

The Policyholder may terminate this policy at any time. If the Policyholder fails to pay premiums when due or within the grace period, We will consider notice to have been given to terminate this policy on the date premium was due.

We will refund any unearned premium from the date of termination.

Policy termination will not affect a claim for a loss due to an Accident that occurred while this policy was in effect.

CONFORMITY WITH STATE STATUTES

Any provision of this policy in conflict with the laws of the state where it is issued on the Policy Effective Date is amended to conform to the minimum requirements of such laws.

LEGAL ACTIONS

No legal action to recover under this policy can be brought for at least 60 days after We have been given written proof of loss. No legal action can be brought after three years from the time written proof of loss is required to be given to Us.

CERTIFICATES OF INSURANCE

We will deliver a certificate of insurance to the Policyholder for delivery to the Insured, in those states in which it is required. Each certificate will list the benefits, conditions, and limits of this policy

DEFINITIONS

The following capitalized terms have the meaning assigned to them in this section. The assigned definitions apply to both the singular and plural forms of the defined term.

Accident means an unexpected and unintended event, independent of sickness and all other causes, which:

- causes Injury to an Insured; and
- occurs within the Scope of Coverage.

Ambulance Service (Air) means the service provided:

- by means of a fixed or roto-winged aircraft equipped with life support and medical apparatus; and
- for the primary purpose of transporting an Insured to or from the Hospital where treatment is given.

Ambulance Service (Surface) means the service provided:

- by a commercial or municipal ground ambulance service; and
- for transporting an Insured to or from the Hospital where treatment is given.

Allowable Expense means a Medical Expense otherwise payable under the policy that is not in excess of the 80th percentile identified on Context4HealthCare (the "Database"). When there is, in Our determination, minimal data available from the Database for a Medical Expense, We will determine the amount to pay by calculating the unit cost for the applicable service category using the Database and multiplying that by the relative value of the Medical Expense based upon a commercially available relative value scale selected by Us. In the event of an unusually complex medical procedure, a Medical Expense for a new procedure or a Medical Expense that otherwise does not have a relative value that is in Our determination applicable, We will assign a relative value. The Medical Expenses We pay may not reflect the actual charges of a provider and does not take into account the provider's training, experience or category of licensure. A provider may charge the Insured the difference between what the provider charges and the amount We pay under the policy. The Database will be updated by us as information becomes available from the supplier, up to twice each year. We may modify the Database to reflect Our experience. We have the right to substitute or replace the Database with another database or databases of comparable purpose, with or without notice.

Ambulatory Surgical Center means a surgical or medical center which:

- has permanent facilities for surgery;
- has an organized medical staff of Physicians and graduate registered nurses (R.N.);
- is authorized by law in the jurisdiction in which it is located to perform surgical services; and
- is licensed (if no license is required, officially approved) under the law.

Benefit Period means the period of time, as stated in the Schedule, from the date of the Injury within which benefits will be paid.

Controlled Substance means any drug or substance, other than alcohol, having the capacity to affect behavior and that is regulated by law with regard to possession and use.

Deductible (Reducing) means the amount of eligible Medical Expenses incurred by an Insured for each loss before benefits are payable under this policy. Medical Expenses payable under any Other Insurance Plan will be used to satisfy or reduce this Deductible. It applies separately to each Insured and each Injury.

Hospital means an institution which:

- is operated pursuant to law;
- is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
- is under the supervision of a staff of Physicians;
- provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.); and
- has medical, diagnostic and treatment facilities, with major surgical facilities on its premises or available to it on a prearranged basis.

Hospital does not include:

- a clinic or facility for:
  - convalescent, custodial, educational or nursing care;
  - the aged, drug addicts or alcoholics;
  - rehabilitation; or
- a military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
  - the services are rendered on an emergency basis; and
  - the individual has a legal liability to pay for the services given in the absence of insurance.

Immediate Family Member means a spouse or domestic partner or civil union partner or a child, parent, grandparent, brother or sister of the Insured, or step-relatives in these same categories, or a person who reared the Insured, or a person whom the Insured reared.

Injury means bodily harm which:

- requires treatment by a Physician;
- results in loss due to an Accident, independent of sickness and all other causes; and
- occurs within the Scope of Coverage.

Bodily harm does not include a Pre-Existing Condition.

Insured means a person:

- who is eligible for insurance under the terms of the policy; and
- for whom proper premium has been paid.

Intensive Care Unit means a section, ward, or wing within a Hospital which is separated from other Hospital facilities and:

- is operated exclusively for the purpose of providing professional treatment for critically ill or Injured patients;
- has special supplies and equipment necessary for such treatment which is available on a standby basis for immediate use;
- provides room and board, and constant observation by registered graduate nurses or other specialty trained Hospital personnel; and
- is not maintained for the purpose of providing normal post-operative recovery treatment or service.

Intoxicated, intoxication means the Insured's condition as determined and defined by the laws in the jurisdiction in which the loss or cause of loss was incurred; (for the purposes of this exception, the laws governing the operation of motor vehicles while intoxicated will apply to any activity occurring at the time of the accident.)

Laboratory Tests means laboratory procedures identified in Physician Current Procedural Terminology (CPT) as codes 80000-89999 inclusive.

Loss of a Foot means Severance above the ankle.

Loss of a Hand means Severance at or above the wrist.

Loss of Hearing means total and permanent loss of hearing which cannot be corrected by any means.

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

Loss of Speech means total, permanent and irrecoverable loss of audible communication.

Loss of a Thumb and Index Finger of the same hand means Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand) from the same Accident.

Loss Period means the period of time stated in the Schedule from the date of an Accident within which the Insured must seek initial treatment for an Injury or death or Specific Loss must occur.

Maximum Benefit Amount means the total benefits payable under an applicable benefit provision. The Maximum Benefit Amount is shown in the Schedule.

Medical Expenses means expenses incurred for Medically Necessary services and supplies. Medical Expenses are incurred on the date the service or supply is rendered or provided.

Medically Necessary, Medical Necessity means care that is ordered, prescribed, or rendered by a Physician or Hospital, and is determined by Us, or a qualified party or entity selected by Us, to be:

- consistent with the diagnosis and treatment of the loss;
- appropriate with the standards of good medical practice;
- not solely for the convenience of the Insured;
- the most appropriate supply or level of service which can be safely provided; and
- not considered experimental or investigative.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it medically necessary or covered by the Policy.

Nurse means a professional, licensed, graduate registered nurse (RN), a professional, licensed practical nurse (LPN) or a certified registered nurse anesthetist (CRNA).

Nurse Practitioner means a licensed registered nurse who has received special training for diagnosing and treating routine or minor ailments.

Orthopedic Appliances means braces and appliances that:

- are prescribed by a Physician;
- are primarily and customarily used to serve a medical purpose;
- can withstand repeated use; and
- are Medically Necessary.

Other Insurance Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- any individual, group, blanket, or franchise policy of accident, disability, or health insurance;
- any arrangement of benefits for members of a group, whether insured or uninsured;
- any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans, or health maintenance organizations;
- any amount payable for Hospital, medical, or other health services for Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy;
- any amount payable for services for injuries or diseases related to the Insured's job to the extent that the Insured actually receives benefits under a workers compensation law. If the Insured enters into a settlement to give up the Insured's rights to recover future medical expenses under a workers compensation law, this policy will not pay those medical expenses that would have been payable except for that settlement; or
- any benefits payable under any program provided or sponsored solely or primarily by any federal, state, or local governmental unit or agency or subdivision or through operation of law or regulation, except Medicaid and Tricare.

Outpatient Surgical Center means a surgical or medical center which has:

- permanent facilities for surgery;
- organized medical staff of Physicians and Nurses; and
- is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

Paralysis means loss of function of one or more limbs as a result of neurological damage, without Severance of a limb. Paralysis must start within the Loss Period stated in the Schedule. This loss must be determined by a Physician to be complete and irreversible. The Insured must be under the care of a Physician for 12 consecutive months from the date of loss of function. At the end of this time, a Physician must determine that the loss of function is not reversible.

Physician means a legally qualified physician, Nurse Practitioner or Physician's Assistant practicing within the scope of his or her license; and recognized as a physician in the state where services are rendered. Physician does not include:

- the Insured; or
- an Immediate Family Member; or
- a person living with the Insured; or
- a person employed or retained by the Policyholder.

Physician's Assistant (PA) means a medical professional, other than the Insured, who is trained and licensed to provide basic medical services under the direction of a Physician.

Pre-Existing Condition means any condition for which an Insured has received care, diagnosis or advice from a Physician or of which symptoms were manifested within 12 months before being covered by this policy.

Prescription Drugs means drugs which:

- under Federal law may only be dispensed by written prescription; and
- are approved for general use by the Food and Drug Administration.

Scope of Coverage means insurance coverage limited to a loss which:

- is within the scope of the risks specified in the INSURED RISKS section of this policy;
- is specified in the DESCRIPTION OF BENEFITS section of this policy;
- occurs during the Loss Period for the loss incurred specified in the Schedule, if any; and
- occurs while this policy is in effect.

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

Sponsored or Supervised Activity means a Policyholder authorized function:

- in which the Insured participates; and
- which is organized by or under its auspices and sanctioned by the appropriate governing authority; and
- which is within the scope of customary activities for such entity.

We, Our, Us means Mutual of Omaha Insurance Company.

X-ray means those procedures identified in Physician Current Procedural Terminology (CPT) as codes 70000-79999 inclusive.

THIS IS A BLANKET LIMITED ACCIDENT POLICY.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.

Mutual of Omaha Insurance Company

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Mutual of Omaha

3300 Mutual of Omaha Plaza
Omaha, NE 68175

PHYSICAL THERAPY EXPENSE AMENDMENT RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (March 6, 2007, or the Policy Date or Certificate Date, whichever is later)
Rider Premium (included in the policy or certificate premium if no amount is shown)

The following provision is amended by adding the following:

PART A. DEFINITIONS

Physical Therapist means a person who is licensed to practice physical therapy pursuant to Title 2 of the District of Columbia Code.

PART B. AMENDMENT

The Accident Medical Expense Benefit Provision is amended as follows.

When, because of covered Injury, a Physical Therapist evaluates and performs outpatient physical therapy with or without the prescription of or referral by a licensed physician, the expense incurred, up to the Maximum Physical Therapy Benefit, will be paid.

All benefits are subject to the Medical Deductible, if any. Benefits for any one accident will not exceed the Maximum Physical Therapy Benefit or, in the aggregate, the Medical Benefit.

These benefits will not duplicate any benefits payable under any Benefit Provision(s) or riders attached to the policy or certificate.

PART C. EXCLUSIONS AND LIMITATIONS

This rider is subject to the Exclusions and Limitations of the Insuring Provision(s) and Benefit Provision(s) applicable to the Insured.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary

DISTRICT OF COLUMBIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT OF 1992

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purpose

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to assure that policy or contract holders of certain types of insurance policies and contracts are covered up to the statutory levels of protection of contractual benefits in the unlikely event that a member insurer is unable to meet its financial obligations and found by a court of law to insolvent. When a member company is found by a court to be insolvent, the Guaranty Association will assess its other member insurers to provide benefits on any outstanding covered claims of persons who reside in the District of Columbia. However, this additional protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep them in-force, with no change in contractual rights or benefits.

Coverage

The District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association"), established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992, provides insolvency protection for certain types of insurance policies and contracts. **NOTE:** Certain policies and contracts may not be covered or fully covered.

The insolvency protections provided by the Guaranty Association are generally conditioned on an individual being a resident of the District and are the insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they live in another state.

(please turn to next page)

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to **the lesser of:**

- the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- with respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term care insurance benefits;
  - $300,000 for disability insurance;
  - $500,000 for basic hospital, medical, and surgical insurance, or major medical insurance;
  - $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 with respect to any one life ($500,000 in the event of basic hospital, medical, and surgical, and major medical claims).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner, regardless of the number of policies owned.

Exclusions

Policy or contract holders are not protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside that state);
- the insurer was not authorized to do business in the District of Columbia; or
- their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;

- interest rate guarantees that exceed certain statutory limitations;
- dividends, experience rating credits, or fees for services in connection with a policy;
- credits given in connection with the administration of a policy by a group contract holder; or
- allocated annuity contracts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to The District of Columbia Department of Insurance, Securities and Banking (DISB) will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

District of Columbia Life and Health
Insurance Guaranty Association
1200 G St, N.W.
Washington, D.C. 20005
(202) 434-8771

District of Columbia Department of
Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, D.C. 20002
(202) 727-8000