CHUBB®

Underwritten by:

ACE American Insurance Company
A Stock Company
Philadelphia, PA 19106
800-352-4462(Inquiries/customer servce)

Group Supplemental Medical Expense Policy

POLICYHOLDER:	McMullen County Independent School District
POLICY NUMBER:	MDX N18019917
POLICY EFFECTIVE DATE:	September 1, 2023
POLICY ANNIVERSARY DATE:	September 1, 2024 and each September 1 thereafter
STATE OF DELIVERY:	Texas

The Policy takes effect at 12:00 a.m. (midnight) on the Policy Effective Date shown above. In return for payment of the required premiums, We will pay benefits according to the terms and conditions of coverage described in the Policy.

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

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania

JOHN J. LUPICA, President

Juliet Schweidel, Secretary

THIS IS A LIMITED BENEFIT POLICY. IT IS NOT A MAJOR MEDICAL PLAN. THE POLICY IS DESIGNED TO REIMBURSE CERTAIN COVERED EXPENSES, AND IS ONLY AVAILABLE IF AN INDIVIDUAL IS COVERED UNDER A MAJOR MEDICAL PLAN. OUT-OF-POCKET EXPENSES SUBMITTED FOR REIMBURSEMENT MUST BE ELIGIBLE UNDER THE MAJOR MEDICAL PLAN.

PLEASE READ THE POLICY CAREFULLY.
RENEWABLE AT THE OPTION OF THE COMPANY
NON-PARTICIPATING

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATION THAT MUST BE FILED AND POSTED.

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SCHEDULE OF BENEFITS

PREMIUM DUE DATE: Monthly on the 1st day of each month

BENEFIT PERIOD: Calendar Year

ELIGIBILITY WAITING PERIOD: Same as Major Medical Plan

CLASSES OF ELIGIBLE PERSONS AND PLAN BENEFITS:

A person may be insured only under one Class of Eligible Persons even though he or she may be eligible under more than one class. Also, a person may not be insured as a Dependent and an Insured at the same time.

CLASS 1:

All employees of the Policyholder who are working 30 or more hours per week and are enrolled in the Policyholder's Major Medical Plan.

Dependents Eligible: Yes

Dependents are eligible for Coverage under this Policy provided they are covered under the Policyholder's Major Medical Plan, coverage is elected, and the required premium is paid.

HOSPITAL EXPENSE BENEFIT

Maximum Benefit Per Covered Person:	$3,000 Per Benefit Period
Maximum Benefit Per Family:	$3,000 Per Covered Member Per Benefit Period

OUTPATIENT BENEFIT Applies: Yes

Maximum Benefit Per Covered Person:	$250 up to a maximum of 2 Outpatient occurrences per Benefit Period
Maximum Benefit Per Family:	$250 up to a maximum of 4 Outpatient occurrences per Benefit Period
Outpatient Benefit includes Ambulance:	Yes

EMERGENCY ROOM charges for a Covered Accident or Sickness that result in hospital confinement is covered under: Hospital Expense Benefit

DOCTOR'S OFFICE VISITS Applies: No

INITIAL PREMIUM RATES: Monthly

CLASS 1	Ages 39 and under	Ages 40 to 49	Ages 50 and older
Employee Only	$24.82	$32.05	$71.60
Employee & Spouse	$45.58	$58.86	$131.57
Employee & Child(ren)	$64.70	$68.10	$128.38
Family	$84.93	$94.25	$186.48

Premium Source:

Policyholder Contribution: 50% or More
Policyholder Contribution applies to: Employee Only

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 an Insured 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.

"Annual Enrollment Period" means the period of time agreed upon by the Policyholder and the Company each year during which the Employee may elect insurance under this Policy.

"Benefit Period" means the period of time when benefits are payable. The Benefit Period is shown in the *Schedule of Benefits*.

"Calendar Year" means the period that starts with the Covered Person's Effective Date and ends on December 31st of the first year. Each following calendar year will start on January 1st of any year and end on December 31st of that year.

"Coinsurance" means the dollar amount of Covered Expenses, after the Deductible is applied, that are not payable under the Insured's Major Medical Plan.

"Complications of Pregnancy" means a condition requiring Hospital confinement, whose diagnosis is distinct from Pregnancy but adversely affected or caused by Pregnancy, such as: a) acute nephritis or nephrosis; b) cardiac decompensation; c) missed abortion; and d) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will also include: a) non-elective cesarean section; b) termination of ectopic pregnancy; and c) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. However, the term Complication of Pregnancy will not include: a) false labor, occasional spotting, or morning sickness; b) Doctor prescribed rest; c) hyperemesis gravidarum; d) pre-eclampsia; or any similar condition associated with the management of a difficult Pregnancy not consisting of a nosologically distinct Complication of Pregnancy.

"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 as a result of a Covered Accident or Sickness for services or supplies covered under the Insured's Major Medical Plan. The Covered Expense must be Medically Necessary for the condition being treated. 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 a 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, 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.

"Deductible" means the dollar amount of Covered Expenses that must be incurred each Benefit Period by a Covered Person as an out-of-pocket expense before benefits are payable under the Insured's Major Medical Plan.

"Dependent" means an Insured's lawful spouse or domestic partner; or an Insured's unmarried child, from the moment of birth to age 26. A child, for eligibility purposes, includes an Insured's: (a) natural child; (b) adopted child, from the moment the Insured is party in a suit to adopt the child; (c) stepchild; (d) child for whom the insured must provide medical support under a court order or order issued under Texas Chapter 154, Family Code; or (e) grandchild who is dependent on the Insured for federal income tax purposes at the time application for coverage of the child is made. Coverage for a grandchild of the Insured may not be terminated solely because the covered grandchild is no longer a dependent of the Insured for federal income tax purposes.

Insurance will continue for any Dependent child who reaches the age limit and continues to meet the following conditions: 1) the child is handicapped, 2) is not capable of self-support and 3) depends mainly on the Insured for support and maintenance. The Insured must send Us satisfactory proof that the child meets these conditions within 31 days of the child attaining the limiting age. We will not ask for proof more than once a year after the second anniversary of the date the child attains the limiting age.

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.

"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.

"**Durable Medical Equipment**" means medical equipment used in the course of treatment or home care, including but not limited to crutches, braces, trusses, renal dialysis equipment, wheelchairs, walkers, hospital beds, traction equipment and prostheses. Durable Medical Equipment must be Medically Necessary and prescribed by a Doctor.

Durable Medical Equipment does not include adjustments to vehicles, air conditioners, dehumidifiers, humidifiers, elevators, stair gliders, exercise equipment, handrails, improvements made to a residence or place of business, ramps, telephones, whirlpool baths and other equipment which has both a non-therapeutic and therapeutic use.

"**Eligible Person** means an individual that meets a class definition shown in the Schedule of benefits. Unless specifically noted in the provision where it is used, the term does not include Eligible Dependents.

"Enrollment Period" means the period agreed upon by the Policyholder and Us when an Eligible Person may enroll for coverage or an Insured 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) provides 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.

"Hospital Confined" means a stay of 15 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 accidental 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 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 any time other than an Annual Enrollment Period. The following events are all considered Life Status Changes:

1. marriage; domestic partnership;
2. divorce or annulment;
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 Insured's spouse that affects either person's eligibility for benefits.

"Major Medical Plan" means any one of the following types of policies or plans which provide benefits for Hospital Confinement for a Covered Person on his or her effective date of coverage, and such policy or plan requires a Covered Person to pay a Deductible and/or portion of Coinsurance: group or blanket insurance plans; group Blue Cross, Blue Shield, or other group prepayment coverage plans; coverage under labor-management trusteed plans, union welfare plans, employer organizational plans, employee benefit organizational plans, or other arrangements of benefits for persons of a group. "Major Medical Plan" does not include Medicare or Medicaid.

"Medical Emergency" means a condition caused by an Injury or Sickness that manifests itself by symptoms of sufficient severity that a prudent layperson 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. We may consider the cost of the alternative to be the Covered Expense.

"**Plan Year**" means a consecutive 12 month period during which an Insured's insurance is in force. An Insured's first Plan Year begins on the later of the effective date of this Policy or other qualifying event as specified in the Policyholder's Major Medical Plan, and ends on the Policy Anniversary Date. Dependents will have the same Plan Year as the Insured.

"Prescription Drug" means drugs dispensed by a licensed pharmacist for which the law requires a Doctor's written prescription. Prescription Drugs include insulin and the needles and syringes required for its administration, if the Covered Person has a Doctor's authorization for such supplies on record with the pharmacist.

"Sickness" means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under this Policy. Sickness includes both normal pregnancy and Complications of Pregnancy. 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

Eligibility requirements are defined in the Policyholder's application. To be eligible, the Insured must be covered under a Major Medical Plan.

Insurance may be available to Dependents only if the Insured is eligible for insurance under this Policy. An Insured's Dependents will be eligible for insurance under the Policy if the Dependent meets the eligibility requirements in the Policyholder's application and is covered under a Major Medical Plan.

New Eligible Persons may be added from time to time. In no event will coverage for any person become effective before the Policy Effective Date.

We maintain 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.

EFFECTIVE DATE OF INSURANCE

Subject to payment of the required premium, an Insured's coverage will be effective on the later of the:

1. first day of the month following the Insured's date of hire;
2. date shown in the Schedule of Benefits;
3. first day of the month;
4. 15th of the month;
5. date of receipt of the Insured's individual enrollment form; or
6. date coverage under the Major Medical Plan goes into effect for that Insured.

Subject to payment of the required premium, a Dependent's coverage will be effective on the later of the:

1. first day of the month following the date the Dependent first became eligible;
2. date shown in the Schedule of Benefits;
3. first day of the month;
4. 15th of the month;
5. date of receipt of the Dependent's individual enrollment form; or
6. date coverage under the Major Medical Plan goes into effect for that Dependent.

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 Insured 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 Insured will be covered on the same basis as a newborn child from the date of placement for the purpose of adoption or the moment the Insured is a party to a suit in which the Insured seeks to adopt the child. Coverage continues unless the placement is disrupted and the child is removed from placement.

Late Enrollees

If an Insured does not apply for coverage on the Insured's initial eligibility date, the Insured may not apply for coverage for the Insured and/or any of the Insured's Dependent's until the next Policy Anniversary Date or qualifying event as specified in the Policyholder's Major Medical Plan.

TERMINATION DATE OF INSURANCE

A Covered Person's coverage will end on the earliest of the date:

1. the Policy terminates;
2. the Covered Person is no longer eligible;
3. the period ends for which premium is paid;
4. the date the Insured's Active Service ends.
5. the date the Covered Person's coverage under a Major Medical Plan is no longer in effect.

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;
3. the period ends for which premium is paid.

COBRA CONTINUATION OF BENEFITS

Applicability
Federal Law requires that employers of 20 or more employees offer temporary extension of health coverage to Qualified Beneficiaries of Employees employed at least 50% of the preceding year when coverage would otherwise end because one or more of the Qualifying Events listed below occurs. Under COBRA, a Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not: 1) already covered under the Policy by reason of another individual's election of COBRA Continuation Benefits, or 2) entitled to Medicare benefits under Title XVIII of the Social Security Act.

Qualifying Event
For purposes of coverage under COBRA, the term Qualifying Event means, with respect to any Covered Person, any of the following events that, but for the continuation coverage required under the law, would result in the loss of coverage for a Qualified Beneficiary.

Qualifying Event	Coverage Continuation Period
• Death of an Insured	36 months
• Termination of employment for any reason except gross misconduct, or a reduction in hours that would result in loss of coverage	18 months*
• Divorce or legal separation	36 months
• The Insured becomes eligible for Medicare	Dependents allowed 36 months
• An insured Dependent no longer meets the eligibility requirements	36 months

* Coverage may be continued for an additional 11 months if the Qualified Beneficiary:
1. is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
2. notifies the plan administrator within 60 days from determination but before the 18-month continuation period ends.

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months from all Qualifying Events.

Notice and Election
Insureds are responsible for notifying their employer in the case of divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The employer must notify the plan administrator of the Qualifying Event. The employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of: 1) the date that coverage would end under the Policy by reason of a Qualifying Event: or 2) the date the Qualified Beneficiary receives notice of his or her COBRA election rights from the plan administrator.

Premium Payment
The Qualified Beneficiary must pay to the employer the required monthly premium. Any Grace Period applying to the employer will also apply to the Qualified Beneficiary, except for the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of the election.

Termination of Continued Benefits
Benefits continued under COBRA will end on the first date that one of the following events occurs:

1. The premium for continued coverage is not paid within 31 days from when it is due;
2. The Qualified Beneficiary becomes covered under another group medical plan providing the same or similar benefits, if that plan does not contain any exclusion or limitation on any pre-existing conditions of the Qualified Beneficiary;
3. The Qualified Beneficiary becomes eligible for Medicare;
4. The Qualified Beneficiary, who is divorced from an insured employee, remarries and is covered under the new spouse's medical plan; or
5. The employer no longer provides group health plan benefits of any kind.

PREMIUMS: Premiums are payable on a monthly basis, unless We agree to some other mode of payment. Premium must be paid to Us at Our Home Office or to Our authorized administrator. The payment of any premium will keep the coverage in force to the next premium due date, subject to the Termination provision.

GRACE PERIOD: If any premiums are not paid by the Premium Due Date, a Grace Period of 31 days will be granted for the payment of the required premiums. Coverage under the Policy will remain in force during the Grace Period. If the required premiums are not paid during the Grace Period, insurance will end as of the last day of the period for which premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time coverage under the Policy was in force.

DESCRIPTION OF BENEFITS

HOSPITAL EXPENSE BENEFIT including Emergency Room; including Durable Medical Equipment

We will pay up to the Total Maximum Benefit per Benefit Period as stated in the Schedule of Benefits if a Covered Person is Hospital Confined as a direct result of an Injury sustained in a Covered Accident or Sickness and the expenses are covered by the Insured's Major Medical Plan. Hospital Confinement must begin after the Policy Effective Date.

Emergency Room
Benefits are payable for Covered Expenses if a Covered Person receives Hospital emergency room treatment for a Medical Emergency and the Covered Person is Hospital Confined within 48 hours of the Hospital emergency room treatment. Benefits are subject to the Maximum Benefit per Benefit Period shown in the *Schedule of Benefits.*

Durable Medical Equipment
Benefits are payable for Covered Expenses for Durable Medical Equipment received by the Covered Person while Hospital Confined. Covered Expenses for Durable Medical Equipment are subject to the Maximum Benefit per Benefit Period shown in the *Schedule of Benefits*.

Ambulance
Benefits are payable for Covered Expenses if a Covered Person requires ambulance transportation to a Hospital for an Injury or Sickness, and the Covered Person is Hospital Confined within 24 hours of being transported to the Hospital. Covered Expenses for ambulance transportation are subject to the Maximum Benefit per Benefit Period shown in the *Schedule of Benefits*.

All Hospital Expense Benefits are limited to out-of-pocket expenses incurred by the Covered Person, including:

(a) The Deductible the Covered Person is required to pay under the Insured's Major Medical Plan.
(b) The Coinsurance amount the Covered Person is required to pay under the Insured's Major Medical Plan.

All benefits are paid on the basis of the expenses actually incurred.

OUTPATIENT BENEFIT I (per occurrence) including Ambulance; including Durable Medical Equipment; including treatment in a Doctor's office

We will pay up to the Maximum Benefit shown in the *Schedule of Benefits* for Outpatient treatment of an Injury sustained in a Covered Accident or Sickness. Benefits are limited to the difference between the amount paid by the Insured's Major Medical Plan and the actual Covered Expenses incurred, including any out-of-pocket expenses such as Deductibles and Coinsurance. Related conditions and recurrent symptoms resulting from an Injury or Sickness are considered a single Injury or Sickness, unless separated by a period of 90 consecutive days. These services will be covered only to the extent that they are provided by, or under the supervision of, a Doctor at a Doctor's Office or a Hospital, outpatient surgical facility, Hospital emergency room, diagnostic testing facility or similar facility that is licensed to provide outpatient treatment.

Benefits are not payable under this Outpatient Benefit for any expenses incurred for an examination of a Covered Person by a Doctor in the Doctor's office or any other facility.

Durable Medical Equipment - Benefits are payable for Covered Expenses for Outpatient Durable Medical Equipment received by the Covered Person. Covered Expenses for Durable Medical Equipment are subject to the Outpatient Maximum Benefit per Benefit Period shown in the *Schedule of Benefits*.

Ambulance - Benefits are payable for Covered Expenses if a Covered Person requires ambulance transportation to a Hospital for an Injury or Sickness, and the Covered Person is not Hospital Confined within 24 hours of being transported to the Hospital. Covered Expenses for ambulance transportation are subject to the Outpatient Maximum Benefit per Benefit Period shown in the *Schedule of Benefits*.

This benefit is in lieu of any Hospital Expense Benefits.

EXCLUSIONS

We will not pay benefits for any loss, treatment or services resulting from or contributed to by:

- intentionally self-inflicted Injury.
- suicide or attempted suicide.
- war or any act of war, whether declared or not.
- active duty service in the military, naval or air force of any country or international organization.
- repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration;
- repair, replacement, examinations for prescriptions or the fitting of eyeglasses or contact lenses.
- Out-of-pocket medical expenses for which the Covered Person is entitled to benefits under any Worker's Compensation Act, Employer's Liability Laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
- treatment or services for Injury or Sickness provided outside of the United States.
- Injuries or loss that happen while the Covered Person is committing or attempting to commit a felony; or actively participating in a riot, or insurrection; or while the Covered Person is legally intoxicated (as determined by that state's laws) or while under the influence of any drug unless administered under the advice and consent of a Doctor.
- Treatment which is not Medically Necessary or medical expenses which do not result from the treatment of an Injury or Sickness.
- Treatment for dental or vision care not related to an accidental Injury.
- Treatment for Injury or Sickness that is payable under any insurance that does not require Deductible and/or Coinsurance payments by the Covered Person.
- Treatment for Injury or Sickness for which benefits are not payable under the Covered Person's Major Medical Plan.
- Treatment for Injury or Sickness if, on the Covered Person's Effective Date of Coverage, the Covered Person was not covered by a Major Medical Plan. Our sole obligation will be to refund all premiums paid.
- Prescription Drugs except medicines prescribed by a Doctor while Hospital Confined.
- Balance billing amounts incurred for non-network providers under the Covered Person's Major Medical Plan.
- Expenses related to wellness visits or preventative services, including annual routine examinations and well-child care.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations applicable to a U.S. policy enforced by the Office of Foreign Assets Control (OFAC) 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 20 days after any loss covered by the Policy occurs. Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice in that time; and notice was given as soon as reasonably possible. This notice should identify the Insured 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 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: All benefits will be paid directly to the Insured or the Insured's assignee on a reimbursement basis. We will reimburse the Insured or the Insured's assignee for the actual payments made up to the amounts payable under the Policy within 60 days of receiving 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; and
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.

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 3 years 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 60 days advanced written 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.

Payment of Premium: The first Premium is due on the Policy Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period: A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

Schedule of Affiliates: Eligible Persons employed by any affiliate or subsidiary corporation of the Policyholder as of the Policy Effective Date are covered under the Policy. Their coverage will begin and end in accordance with the Effective Date of Insurance and Termination Date of Insurance provisions in the Policy. A list of these affiliates and subsidiaries must be kept on file with the Company.

Newly Acquired Organizations: The premium shown on the *Schedule of Benefits* applies only to the Policyholder and any affiliates or subsidiary corporations covered on the Policy Effective Date. However, eligible employees of organizations acquired by the Policyholder during the Policy Term may be covered based on the following terms. The Policyholder must: (1) report to Us within 60 days of the acquisition the name of the newly acquired organization and any underwriting information We may need to calculate the premium; and (2) the required additional premium, if any, must be paid.

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.

Policy Effective Date and Termination Date: The Policy begins on the Policy Effective Date at 12:00 a.m. (midnight) at the address of the Policyholder where this Policy is delivered. We may terminate this Policy by giving 31 days advance notice in writing (or authorized electronic or telephonic means) to the Policyholder. Either We or the Policyholder may terminate this Policy on any Premium Due Date by giving 31 days advance written (or authorized electronic or telephonic) notice to the other party. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Policyholder and Us. This Policy terminates automatically on the Premium Due Date if Premiums are not paid when due. We may cancel the Policy as of any Premium Due Date if Participation Requirements are not met or on the date the Major Medical Plan is modified or terminated, unless We have approved in writing any such modifications.. Termination takes effect at 12:00 a.m. (midnight) at the Policyholder's address on the date of termination.

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.

Examination of Records and Audit: We shall be permitted to examine and audit the Policyholder’s books and records at any time during the term of the Policy and within 2 years after the final termination of the Policy as they relate to the premiums or subject matter of this insurance.

Certificates of Insurance: 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.

Subrogation: We may recover any benefits paid under the Policy to the extent a Covered Person is paid for the same Injury or Sickness by a third party, another insurer, or the Covered Person’s uninsured motorists insurance. We may only be reimbursed to the amount of the Covered Person’s recovery. Further, We have the right to offset future benefits payable to the Covered Person under the Policy against such recovery.

Upon request the Covered Person must complete the required forms and return them to Us or Our authorized agent. The Covered Person must cooperate fully with Us or Our representative in asserting its right to recover. The Covered Person will be personally liable for reimbursement to Us to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for Us to institute legal action against the Covered Person for failure to repay Us, the costs of collection, including reasonable attorneys' fees, will be apportioned between Us and the Covered Person by the court. The total attorney's fees may not exceed one-third of the recovery.

Chubb. Insured.℠

CHUBB®

CHUBB GROUP
U.S. PRIVACY NOTICE

FACTS	WHAT DOES THE 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?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ▪ Social Security number and payment history ▪ insurance claim history and medical information ▪ account transactions and credit scores When you are no longer our customer, we continue to share information about you as described in this notice.
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** https://www2.Chubb.com/us-en/privacy.aspx

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 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 Fire and Marine 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, Texas Pacific Indemnity 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 June 15, 2018.

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 ("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 also 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 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 and to permit product recalls and to conduct post-market surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of 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 public 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 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 a victim of a crime but only if the individual agrees to the disclosure or the covered entity 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 of 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 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: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

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 to: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

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 to 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 to: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

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: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) 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: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

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 HHS;
- 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 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 the Company, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Company Sponsor has provided health benefits under the Company; 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 in care of: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.

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: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

VI. Chubb Group Legal Entities

This following is a list of the Chubb Group 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.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). This notice summarizes your protections.

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- Accident, accident and health, or health insurance (including HMOs):
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- Life insurance:
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- Individual annuities: Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- Other policy types: Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- Individual aggregate limit: Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- Parts of some policies might not be protected: For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact	For questions about insurance, contact
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701 1-800-982-6362 or www.txlifega.org	Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act

(Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. There may be other exceptions that aren't included in this notice. When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

TEXAS NOTICE

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: ConsumerProtectoin@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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 111-1A, P.O. Box 149091, Austin, TX 78714-9091