SUMMARY PLAN DESCRIPTION

# VOLUNTARY AD&D INSURANCE

Effective July 1, 2020

# Voluntary AD&D Insurance Program
# Benefit Program Summary Plan Description
# Effective as of July 1, 2020

Accidental death and dismemberment ("AD&D") insurance provides financial protection for you and your family in the event of a serious accident or death. The Voluntary AD&D Insurance Program ("Program") allows you to purchase additional AD&D insurance for you and your dependents in addition to the Basic AD&D Insurance Program, which is 100% Employer paid. If you elect to participate in the Program, you will pay for this coverage.

The Program is fully insured by Gerber Life Insurance Company ("Insurance Company"). The following pages include a Certificate of Insurance issued by the Insurance Company (which may also include riders, endorsements or other related attachments) (together, the "Certificate"). The Certificate describes the terms and provisions of the insured benefits provided.

About the Summary Plan Description:
The Program is a part of the Occidental Petroleum Corporation Welfare Plan (the "Plan").* The full Summary Plan Description consists of a wrap-around summary plan description document ("Wrap-SPD") and the Benefit Program Summary Plan Descriptions ("Benefit Program SPDs") for each benefit program under the Plan.

This document that you are reading is the Benefit Program SPD for the Program. This Benefit Program SPD must be read together with the Wrap-SPD because both documents contain terms and provisions that are applicable to the Program. For additional information regarding the interaction of this Benefit Program SPD (including the Certificate) with the Wrap-SPD, please consult Article II "Interpretation" of the Wrap-SPD.

To view the Wrap-SPD click here. Alternatively, to request a hardcopy or an electronic copy please contact the OxyLink Employee Service Center (OxyLink) by email or call 1-800-699-6903 (inside US) and 1-918-610-1990 (outside US) and an OxyLink representative will be happy to assist you.

* The Program is provided under the "General Health & Welfare Component" of the Plan. Other benefits unrelated to the Program are provided under a separate component of the Plan. For purposes of this Benefit Program SPD, references to the "Plan" will mean the General Health & Welfare Component unless otherwise specified or appropriate in context.

# Texas Important Notice

## Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company 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. If you don't, you may lose your right to appeal.

**Zurich North America**
To get information or file a complaint with your insurance company

**Call: Customer Inquiry Center at 1-847-413-5438**

**Toll-free: 1-800-382-2150**

Email: info.source@zurichna.com
Mail: 1299 Zurich Way, Schaumburg, IL 60196-1056

**The Texas Department of Insurance**
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC111-1A, P.O. Box 149091, Austin, TX 78714-9091

## ¿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. 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. Si no lo hace, podría perder su derecho para apelar.

**Zurich North America**
Para obtener información o para presentar una queja ante su compañía de seguros:

**Llame a: Customer Inquiry Center at 1-847-413-5438**

**Teléfono gratuito: 1-800-382-2150**

Correo electrónico: info.source@zurichna.com
Dirección postal: 1299 Zurich Way, Schaumburg, IL 60196-1056

**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

# Group Accident Policy

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

In return for the payment of premium expressed in the **Schedule**, **We** agree to pay the benefits of this Group **Accident Policy** to the persons insured hereunder, subject to the terms and conditions which follow. **We** have issued the Group **Accident Policy** to the **Policyholder**. The Group **Accident Policy** is executed as of the **Policy** date which is its date of issue, and from which anniversary dates are measured. The Group **Accident Policy** is delivered in, and subject to the laws of the Contract Situs in which it is issued.

**THIS GROUP ACCIDENT INSURANCE POLICY PROVIDES ACCIDENT COVERAGE ONLY**
**THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS**

**POLICYHOLDER**: Occidental Petroleum Corporation
5 Greenway Plaza, Suite 110
Houston, TX 77046-0521

**POLICY** NUMBER: GTU 7781876

**POLICY** DATE: January 1, 2022 to Continuous
(All Insurance begins and ends at 12:01 a.m. at **Policyholder's** Address)

CONTRACT SITUS: Texas

The following pages, including any riders, endorsements, schedule pages, **Insured** enrollment forms, applications or amendments, are a part of this Group **Accident Policy**. **We** and the **Policyholder** have agreed to all the terms of this Group **Accident Policy**.

This is a legal contract between the **Policyholder** and **Us**.
READ THE GROUP **ACCIDENT POLICY** CAREFULLY

In Witness Whereof, **We** have caused this **Policy** to be executed and attested, and, if required by state law, this **Policy** will not be valid unless countersigned by **Our** authorized representative.

Kristof Terryn
President
Zurich American Insurance Company

Laura J. Lazarczyk.
Corporate Secretary
Zurich American Insurance Company

**NON-PARTICIPATING**

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## SECTION I – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

**ELIGIBILITY AND CLASSIFICATION OF INSUREDS:**

The following individuals are eligible to become **Insureds** upon the submission of completed enrollment material, if required:

**Class I:**

1) All regular full-time non-bargaining hourly or salary Employees regularly scheduled to work at least twenty (20) hours per week on U.S. Dollar Payroll of Occidental Petroleum Corporation or an **Affiliated Company** (Oxy). Temporary Employees and Employees of certain **Affiliated Companies** designated by Oxy are not eligible to participate. An **Affiliated Company** means any company in which 80 percent or more of the equity interest is owned by Occidental Petroleum Corporation. Employees who are part of a collective bargaining group are eligible to participate in the Plan only if the negotiated bargaining agreement specifically provides for participation.

2) Part-time Non-bargaining hourly or salary Employees who are eligible for retiree medical coverage (at least age 60 and 10 or more years of regular full-time service).

3) All **Active** Employees represented by United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO, Local 620 (Geismar, LA)

4) All **Active** Employees represented by The International Union of Operating Engineers, AFL-CIO, Local 119 (Wichita, KS)

5) Disabled individuals who are eligible to continue their AD&D coverage, as originally issued under policy GTU 8364499 issued by Zurich American Insurance Company, through the duration of their Long-Term Disability (LTD) claim approval, whose names are on file with the Company.

If an **Insured** suffers an **Injury** resulting in a **Covered Loss,** and he or she is covered under more than one class, **We** will pay only one benefit, the largest benefit.

**ELIGIBILITY OF INSURED'S DEPENDENTS:**

Individuals who enroll may elect to cover their eligible **Dependents.** An eligible **Dependent** includes the **Insured's** legally married **Spouse/Domestic Partner** and the **Insured's Dependent Child(ren)**. A legally married **Spouse/Domestic Partner** will not be eligible as a **Dependent** if he or she is also an **Insured** under this **Policy**. If the **Insured** and his or her legally married **Spouse/Domestic Partner**, legally separated **Spouse/Domestic Partner,** former **Spouse/Domestic Partner** are both **Insured's** under this **Policy**, only one may select a **Plan** covering their mutual **Dependents**.

**EFFECTIVE DATE OF INSURANCE FOR THE INSURED:**

A. For eligible individuals hired prior to January 1, 2022:
The **Policy** effective date.

B. For eligible individuals hired on or after January 1, 2022:
The date of hire.

## SECTION II – SCHEDULE

| **COVERAGES(S):** | **Classes Covered** |
|---|---|
| 24 Hour **Accident** Protection, Business and Pleasure Including Corporate Owned or Leased Aircraft, and Substitute Aircraft, Passenger and Crew H-1 | All |
| Exposure and Disappearance Coverage | All |
| War Risk Coverage | All |

**BENEFITS:** **Classes Covered**

**ACCIDENTAL DEATH BENEFIT** All

**Principal Sum**:

**Class I:**

1) An amount equal to one (1) to ten (10) times the employee's **Base Annual Earnings*** subject to a minimum of $10,000 and a maximum of $1,500,000 rounded to the next higher even multiple of $10,000, if not already an even multiple of $10,000.

2) An amount equal to one (1) to ten (10) times the employee's **Base Annual Earnings* s**ubject to a minimum of $10,000 and a maximum of $1,500,000 rounded to the next higher even multiple of $10,000, if not already an even multiple of $10,000

3) $5,000, $10,000 or $15,000

4) $5,000, $10,000 or $15,000

5) As on file with the Company.

***** **Base Annual Earnings** means:

1. For exempt employees, base pay defined as only the employee's regular salary.
2. For non-exempt employees, base pay defined as only the employee's scheduled straight time hourly wages and regularly scheduled overtime.
3. For exempt and non-exempt employees, earnings excludes bonuses, unscheduled overtime, geographic premiums, other premiums, or additional forms of compensation.

The **Principal Sum** for **Covered Dependents** will be the following amounts:

**Spouse/Domestic Partner**: 100% or 50% of the **Insured's Principal Sum**

**Dependent Child(ren)**: $20,000

In no event will the amount be greater than the **Insured's Principal Sum.**

**Classes Covered**

**ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT** All

**Principal Sum**:

Same as above.

Accidental Dismemberment and Covered Loss of Use Benefit for Dependent Children — All

Coma Benefit — All

**ADDITIONAL BENEFITS:** **Classes Covered**

| | |
|---|---|
| Continuation of Insurance Benefit | All |
| Critical Burn Benefit | All |
| Day Care Benefit | All |
| Felonious Assault Benefit | All |
| Higher Education Benefit | All |
| Home Alteration And Vehicle Modification Benefit | All |
| Rehabilitation Benefit | All |
| Seat Belt/Air Bag Benefit | All |
| Spouse/Domestic Partner Retraining Benefit | All |
| Therapeutic Counseling Benefit | All |
| Travel Assistance Plan | All |

| ADDITIONAL ENDORSEMENTS | Form Number | Classes Covered |
|---|---|---|
| Expanded Coverage | U-VA-207-A CW (09/21) | All |
| Amendment to **Policy** Definitions | U-VA-104-A CW (09/06) | |

Enrollment Required: ☒ Yes ☐ No

Premium Due Date: First day of each month

Premium: **Class I**

| | |
|---|---|
| Employee Only: | $0.021 per $1,000 of **Principal Sum** per month |
| **Spouse/Domestic Partner** Only: | plus $0.021 per $1,000 of **Principal Sum** per month |
| **Dependent Children** Only: | plus $0.021 per $1,000 of **Principal Sum** per month |
| Employee & **Dependents**: | $0.021 per $1,000 of **Principal Sum** per month |
| | These rates are guaranteed until January 1, 2025. |

## SECTION III – DEFINITIONS

**Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

**Active** and **Actively at Work** describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered **Actively at Work** provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.

**Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the Schedule. For purposes of the **Aggregate Limit of Liability** provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the **Aggregate Limit of Liability** is not enough to pay full benefits to each **Insured**, **We** will pay each one a reduced benefit based upon the proportion that the **Aggregate Limit of Liability** bears to the total benefits which would otherwise be paid.

**Chartered Aircraft** means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than ten (10) consecutive days and/or for no more than fifteen (15) days in a one (1) year period.

**Controlled** by, as used in the **Coverages** Section, means the **Policyholder** has the right to use a block of aircraft flight time for 25 or more hours in a one (1) year period or for 100 hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.

**Coverage(s)** means the event or events described in the **Hazards** of this **Policy** to which benefits and additional benefits apply. The **Hazards** are listed in the **Coverages** Section on the Schedule.

**Covered Accident** means an **Accident** that results in a **Covered Loss**.

**Covered Injury** means an **Injury** directly caused by accidental means which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under this **Policy**, and results in a **Covered Loss**.

**Covered Loss** means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury,** and for which benefits are payable under this **Policy**.

**Covered Person** means any person who has insurance under the terms of this **Policy**. It includes the **Insured**, and his or her **Spouse/Domestic Partner** and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse/Domestic Partner** and/or **Dependent Child(ren)** is selected.

**Dependent** means an **Insured's Spouse**/**Domestic Partner** and **Dependent Child(ren),** as defined in this section.

**Dependent Child(ren)**, if used in this **Policy,** means those unmarried **Child(ren)** of the **Insured,** and those unmarried **Child(ren)** of his or her legally married **Spouse**, and those unmarried **Child(ren)** as defined in the **Policyholder's** medical plan as on file and approved by **Us** of the **Insured's Domestic Partner** who rely on the **Insured** for more than 50% of their support, and are either: 1) less than twenty-six (26) years of age; 2) less than twenty-six (26) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap.

**Domestic Partner** means as defined in the **Policyholder's** medical plan as on file and approved by **Us**.

**Injury** means a bodily **Injury**.

**Insured** means an individual who is eligible for **Coverage** under this **Policy** as provided in the Eligibility and Classification of **Insureds** part of Section I, and who completes the enrollment material, if required.

**Owned Aircraft** means an aircraft in which the **Policyholder** or a related company has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.

**Plan** means the **Plan** design as described on the Schedule**.**

**Policy** means this Group **Accident** Insurance **Policy**.

**Policyholder** means the group named on the front page of this **Policy**.

**Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:

acrobatic or stunt flying
banner towing
bird or fowl herding
crop dusting
crop seeding
crop spraying
endurance tests
fire fighting
flight on a rocket-propelled or rocket launched aircraft
flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted
hang gliding
hunting
parachuting or skydiving
racing
skywriting
test or experimental purpose

**Spouse**, if used in this **Policy,** means the **Insured's** legally married **Spouse**.

**Under lease**, as used in the **Coverages** Section**,** means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than ten (10) consecutive days and/or for more than fifteen (15) days in a one (1) year period. A **Chartered Aircraft** will not be considered **Under lease**.

**We, Us,** and **Our** refers to Zurich American Insurance Company.

## SECTION IV – COVERAGES

**24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE INCLUDING CORPORATE OWNED OR LEASED AIRCRAFT, AND SUBSTITUTE AIRCRAFT, PASSENGER AND CREW H-1**

**Class All**

The **Hazards** insured against by this **Policy** are:

A **Covered Injury** sustained by a **Covered Person** anywhere in the world, subject to the terms, conditions, exclusions and limitations under this **Policy**.

**Hazard Limitations:**

Air travel **Coverage** is limited to a loss sustained during a trip, while the **Covered Person** is a passenger, pilot, operator, member of the crew or cabin attendant, riding in or on, boarding or getting off:

**A.** any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

**1.** medical certificate; and

**2.** pilot certificate with a proper rating to pilot such aircraft.

**B.** any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

**Hazard Exclusions:**

**Coverage** is not provided:

**A.** If the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft except those aircraft specified below.

**B.** Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:

**1.** any aircraft other than those expressly stated in this **Coverage**;

**2.** any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder** except the following aircraft, including **Substitute Aircraft**

As on File with the **Policyholder**

provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft.

**3.** any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured** or a member of an **Insured's** family or household;

**4.** any aircraft operated by the **Policyholder** except those indicated in 2. above, including **Substitute Aircraft** or one of the **Policyholder's** employees including members of an employee's family or household;

**5.** any aircraft engaged in a **Specialized Aviation Activity;**

**6.** any conveyance used for tests or experimental purposes, or in a race or speed test.

**Hazard Definitions:**

**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:

1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
2. is the same class of aircraft as the specified aircraft; and
3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.

**Note**: A complete updated list of all Corporate Aircraft must be provided to **Us** on each anniversary of the **Policy**.

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

## EXPOSURE AND DISAPPEARANCE COVERAGE

**Class All**

If a **Covered Person** is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which a **Covered Person** is riding disappears, is wrecked, or sinks, and the **Covered Person** is not found within 365 days of the event, **We** will presume that the person lost his or her life as a result of **Injury**. If travel in such conveyance was covered under the terms of this **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the **Covered Person** survived the event.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

## WAR RISK COVERAGE

**Class All**

The exclusion for war or any acts of war, whether declared or undeclared, as found in Section VII General Exclusions of this **Policy** is modified, and **Covered Injuries** directly resulting from war or any acts of war, whether declared or undeclared, are covered under this **Policy** provided:

**A.** the war or act of war causing the **Injury** does not occur within any of the states of the United States of America (including the District of Columbia), Afghanistan, Iraq or the **Covered Person's** country of residence.

**We** may, by giving seven (7) days written notice to the **Policyholder**, (1) require additional premium, to be calculated at the standard war risk rates utilized at the time of the exposure; (2) amend the list of countries above; or (3) cancel this **Coverage**. Any revision or cancellation will not prejudice any claim that occurred prior to the effective date of the revision or cancellation. Any unearned premium at the time of a cancellation will be promptly calculated and returned to the **Policyholder** on a pro-rata basis, but the return of the unearned premium is not a condition of cancellation. **Our** failure to exercise any of **Our** rights under this **Coverage** will not be deemed a waiver of these rights.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

## SECTION V – BENEFITS

### ACCIDENTAL DEATH BENEFIT

If a **Covered Person** suffers a loss of life as a result of a **Covered Injury**, **We** will pay the applicable **Principal Sum**. The death must occur within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VIII General Limitations.

### ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

If an **Injury** to a **Covered Person** or a **Covered Spouse** / **Domestic Partner** results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

| **Covered Loss** of | **Benefit** |
|---|---|
| **1.** Both Hands or Both Feet | **Principal Sum** |
| **2.** One Hand and One Foot | **Principal Sum** |
| **3.** One Hand or One Foot plus the loss of Sight of One Eye | **Principal Sum** |
| **4.** Sight of Both Eyes | **Principal Sum** |
| **5.** Speech and Hearing | **Principal Sum** |
| **6.** Speech or Hearing | 50% of **Principal Sum** |
| **7.** One Hand; One Foot; or Sight of One Eye | 50% of **Principal Sum** |
| **8.** Thumb and Index Finger of the same Hand | 25% of **Principal Sum** |
| **9.** Hearing in One Ear | 25% of **Principal Sum** |

| **Covered Loss of Use** of | |
|---|---|
| **1.** Four **Limbs** | **Principal Sum** |
| **2.** Three **Limbs** | 85% of **Principal Sum** |
| **3.** Two **Limbs** | 75% of **Principal Sum** |
| **4.** One **Limb** | 50% of **Principal Sum** |

For purposes of this benefit:

1. **Covered Loss** means:
    - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
    - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
    - **c.** Total and permanent loss of sight;
    - **d.** Total and permanent loss of speech;
    - **e.** Total and permanent loss of hearing.
2. **Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which has continued for 12 consecutive months and is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.

This benefit is subject to the limitations in Section VIII General Limitations.

**ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT FOR COVERED DEPENDENT CHILDREN**

If an **Injury** to a **Covered Dependent Child(ren)** results in any of the following **Covered Losses**, **We** will pay the benefit shown. The **Covered Loss** must occur within 365 days of the **Accident**.

| **Covered Loss** of | **Percentage** of **Insured's Principal Sum** |
|---|---|
| **1.** Both Hands or Both Feet | 200% to a maximum of $40,000 |
| **2.** One Hand and One Foot | 200% to a maximum of $40,000 |
| **3.** One Hand or One Foot plus the loss of Sight of One Eye | 200% to a maximum of $40,000 |
| **4.** Sight of Both Eyes | 200% to a maximum of $40,000 |
| **5.** Speech and Hearing | 200% to a maximum of $40,000 |
| **6.** Speech or Hearing | 100% to a maximum of $20,000 |
| **7.** One Hand; One Foot; or Sight of One Eye | 100% to a maximum of $20,000 |
| **8.** Thumb and Index Finger of the same Hand | 50% to a maximum of $10,000 |
| **9.** Hearing in One Ear | 50% to a maximum of $10,000 |
| **Covered Loss of Use** of | |
| **1.** Four **Limbs** | 200% to a maximum of $40,000 |
| **2.** Three **Limbs** | 170% to a maximum of $34,000 |
| **3.** Two **Limbs** | 150% to a maximum of $30,000 |
| **4.** One **Limb** | 100% to a maximum of $20,000 |

For purposes of this **Benefit**:

1. **Covered Loss** means:
   - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
   - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
   - **c.** Total and permanent loss of sight;
   - **d.** Total and permanent loss of speech;
   - **e.** Total and permanent loss of hearing.
2. **Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which has continued for 12 consecutive months and is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.

This benefit is subject to the limitations in Section VIII General Limitations.

**COMA BENEFIT**

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** within 31 days of a **Covered Accident**, and such **Injury** causes the **Covered Person** to be in a **Coma** for at least sixty (60) consecutive days, **We** will pay a **Coma Benefit**.

The **Coma Benefit** is equal to 5% of the **Covered Person's Principal Sum**, and will be paid each month the **Covered Person** remains in a **Coma** following the initial sixty (60) day period. The **Coma Benefit** will end on the earliest of the following:

1. the **Covered Person** is no longer in a **Coma** which directly resulted from the **Injury**;
2. the **Covered Person** has received a **Coma Benefit** for 12 months.

**Coma** will be determined by **Our** duly licensed physician.

This benefit is subject to the limitations in Section VIII General Limitations.

## SECTION VI – ADDITIONAL BENEFITS

**CONTINUATION OF INSURANCE BENEFIT**

If an **Insured** selects a **Plan** covering his or her **Dependents,** and the **Insured** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, all **Coverages** under this **Policy** which were in force on the date of the loss, with respect to **Covered Persons** other than the **Insured**, will be continued automatically for 365 days after the date of the loss at no additional cost.

**CRITICAL BURN BENEFIT**

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** as a result of a **Covered Accident,** which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit,** an additional benefit will be payable equal to the lesser of 10% of the **Insured's Principal Sum** or $25,000, provided all terms and conditions of the **Policy** are met and:

1. the **Covered Person** has received second degree or higher burns over 25% of his or her body; and
2. the **Covered Person** has undergone reconstructive surgery to treat the burned areas of the body; and
3. the reconstructive surgery has taken place within 365 days of the occurrence of the **Injury**.

**DAY CARE BENEFIT**

If an **Insured** selects a **Plan** covering his or her **Dependents** and the **Insured** or his or her **Covered Spouse/Domestic Partner** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for day care expenses on behalf of each **Dependent Child** if:

1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within three hundred and sixty-five (365) days from the date of loss; and
2. the **Dependent Child** is under age 13.

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the child care;
2. 5% of the **Principal Sum** of the **Covered Person** who suffered the **Covered Loss**; or
3. $3,000.

If both the **Insured** and his or her **Spouse /Domestic Partner** suffer a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Day Care Benefit** will be based on the **Insured's Principal Sum**.

The **Day Care Benefit** will be paid annually for four (4) consecutive years if:

1. the **Dependent Child** is under age 13 at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

**FELONIOUS ASSAULT BENEFIT**

If an **Insured** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit** as a result of a violent or criminal act committed by someone other than the **Insured**, a **Fellow Employee** or a member of his or her **Family** or **Household**, **We** will pay an additional benefit equal to 10% of the **Insured's Principal Sum**, provided:

1. the **Injury** is incurred in connection with the **Policyholder's** normal business whether on or off the **Policyholder's** premises; and
2. the crime directly involves the **Policyholder's** funds or assets.

For purposes of this benefit:

**Fellow Employee** means a person employed by the same employer as the **Insured** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than forty-five (45) days prior to the date on which the defined violent crime/felonious assault was committed.

**Family** means the **Insured's** parent, step-parent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

**Household** means a person who maintains residence at the same address as the **Insured**.

This benefit applies only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.

**HIGHER EDUCATION BENEFIT**

If the **Insured** selects a **Plan** covering his or her **Dependent Child(ren)** and the **Insured** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**.

A **Dependent Child** is eligible for the **Higher Education Benefit** if on the date of the **Accident**:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The **Higher Education Benefit** will be equal to 5% of the **Insured's Principal Sum**, to a maximum of $5,000. This amount will be paid annually for up to four (4) consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, the **Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.

**HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT**

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, **We** will pay an additional benefit for home alterations and/or vehicle modifications, provided:

1. the **Covered Person** is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the **Injury** that caused the payment of the **Accidental Dismemberment and Covered Loss of Use Benefit** is the same **Injury** that requires the **Covered Person** to need the wheelchair.

The amount **We** will pay will be equal to:

1. the one time cost of alterations to the **Covered Person's** primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to his or her motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 5% of the **Covered Person's Principal Sum** or $10,000.

**REHABILITATION BENEFIT**

If the **Insured** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training,** in an amount equal to the lesser of:

1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the **Rehabilitation Training**;
2. $6,000; or
3. 10% of the **Insured's Principal Sum**.

**Rehabilitation Training** means a treatment program that:

1. is prescribed by a licensed physician acting within the scope of his or her license that is approved by **Us** prior to the provision of services;
2. is required due to the **Insured's Injury**; and
3. prepares the **Insured** for an occupation which he or she would not have engaged in except for the **Injury**.

**Reasonable and Customary** expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

**We** reserve the right to make the final determination of what is **Reasonable and Customary**.

**SEAT BELT/AIR BAG BENEFIT**

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, **We** will pay an additional benefit, which equals 10% of the applicable **Principal Sum** up to a maximum of $50,000 provided that the **Covered Person** was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of the **Covered Person's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

An additional benefit equal to 5% of the **Covered Person's Principal Sum** to a maximum of $20,000, will be paid if the **Insured** was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the **Insured's** seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.

**We** will not pay a **Seat Belt** or **Air Bag Benefit** if the driver of the automobile in which the **Covered Person** was riding was either:

1. under the influence of alcohol;
   a. A driver will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.

**SPOUSE/DOMESTIC PARTNER RETRAINING BENEFIT**

If an **Insured**, selects a **Plan** covering his or her **Spouse/Domestic Partner**, and the **Insured** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, **We** will pay to his or her **Spouse/Domestic Partner**, the actual cost of any professional or trade-training program in which the **Spouse/Domestic Partner** enrolls, provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;
2. the actual cost is incurred within thirty (30) months from the death of the **Insured**; and
3. the professional or trade training program is licensed by the state.

The maximum amount payable under this benefit will be the lesser of 10% of the **Insured's Principal Sum** or $20,000.

**THERAPEUTIC COUNSELING BENEFIT**

If a **Covered Person** selects a **Plan** covering his or her **Dependents** and the **Covered Person** or his or her **Covered Dependents** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit,** and the **Covered Person** or his or her **Covered Dependents** requires **Therapeutic Counseling**, **We** will reimburse the charges for such counseling, to the individual who incurs the expense, provided:

(1) all terms and conditions of the **Policy** are met;

(2) **Therapeutic Counseling** begins within ninety (90) days of the **Covered Accident**;

(3) **Therapeutic Counseling** must be received within one (1) year from the date of the **Covered Loss**.

**Therapeutic Counseling** means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is $6,000 for any one **Covered Accident**.

**TRAVEL ASSISTANCE PLAN**

This **Travel Assistance Plan** will apply to the following **Covered Persons** when they are traveling 100 miles or more from their **Principal Residence**: the **Insured** and his or her **Spouse** (/**Domestic Partner**) and or **Child(ren)** if the **Spouse**/**Domestic Partner** and or **Child(ren)** are with the **Insured** while he or she is covered under this **Policy**. The **Spouse**/**Domestic Partner** or **Child(ren)** will not be covered while making a trip without the **Insured**. The transportation and/or services provided under this **Travel Assistance Plan** must be pre-authorized by **Us**. Under this **Policy,** the **Travel Assistance Plan** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

**Medical Evacuation**

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician.

For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

**Medical Repatriation**

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to his or her **Principal Residence,** or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

**Non-Medical Repatriation**

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending physician. The upgrade will be subject to **Our** sole discretion.

**Return of Remains**

If a **Covered Person** dies while on a **Covered Trip, We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable.

**Visit to Hospital**

If a **Covered Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip, We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Covered Person** to visit the **Covered Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable.

**Return of Child**

If a **Covered Person** is traveling with a **Child(ren),** who is under nineteen (19) years of age or a **Child(ren)** who prior to age nineteen (19) became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Covered Person** for support and maintenance, while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Covered Person,** such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Covered Person,**

and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable.

**Return of Companion**

If a **Covered Person** is traveling with a companion while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Covered Person** the **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable.

- **TRAVEL ASSISTANCE EXCLUSIONS**

**We** will not provide the **Travel Assistance Plan** if the **Coverage** is excluded under Section VII – General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the **Covered Person** being under the influence of any controlled substance, unless such controlled substance was prescribed by a physician and was taken in accordance with the prescribed dosage;
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Covered Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Covered Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or MEDICAL REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services;

- **TRAVEL ASSISTANCE DEFINITIONS**

For purposes of this **Travel Assistance Plan** only, the following definitions apply:

**"Covered Trip"** means when a **Covered Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

**"Illness"** or **"Ill"** means a sickness or disease which impairs normal functions of the body.

**"Injured" "Injury"** or **"Injuries"** means a bodily **Injury** or **Injuries** and is not limited to accidental bodily injuries.

**"Principal Residence"** means the legal domicile of the **Covered Person.**

**"Western Medical Standards"** means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.

For the purpose of the **Travel Assistance Plan**, if there are any differences in the definition of a term between the **Travel Assistance Plan** and the **Policy,** the definition in the **Travel Assistance Plan** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

**Right of Recovery**

**We** have the right to recover any benefits that **We** have paid under this **Travel Assistance Plan** if the **Policyholder** or **Covered Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Covered Person** that were covered under this **Travel Assistance Plan. We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Covered Person** for transportation services and/or expenses, which were not covered under the **Travel Assistance Plan.**

**Reservation of Rights**

**We** reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services.

**Scope**

**Illness**, as covered under this **Travel Assistance Plan,** is solely covered under this **Travel Assistance Plan,** and in no way supercedes or modifies the other **Coverages** provided under this **Policy**.

To contact **Us** regarding this **Travel Assistance Plan**, the **Covered Person** must call 1-800-263-0261 from the U.S. or Canada; and collect from anywhere else in the world at +1-416-977-0277.

## SECTION VII – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service. Reserve or National Guard active duty training is not excluded, unless it extends beyond sixty (60) consecutive days;
4. illness or disease, regardless of how contracted, medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony;
6. being intoxicated while operating a motor vehicle.
   a. A **Covered Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Covered Person's** intoxication.
7. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
8. travel or flight in any aircraft except to the extent stated in the **Coverage** Section.

## SECTION VIII – GENERAL LIMITATIONS

**Limitation on Multiple Covered Losses**. If a **Covered Person** suffers more than one loss as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

**Limitation on Multiple Benefits**. If a **Covered Person** can recover benefits under more than one of the following benefits: **Accidental Death Benefit**, **Accidental Dismemberment and Covered Loss of Use Benefit**, **Coma Benefit,** as a result of the same **Accident,** the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

**Limitation on Multiple Hazards**. If a **Covered Person** suffers a **Covered Loss** that is covered under more than one **Hazard**, **We** will pay only one benefit, the largest benefit.

## SECTION IX - TERMINATION OF INSURANCE

**A. Policy Termination.**

Termination by **Policyholder**. The **Policyholder** may terminate this **Policy** on the first renewal date or at any time after that date by delivering to **Us** a written notice to end this **Policy** at least thirty (30) days in advance of such termination. **We** will calculate and return the unearned premium, if any, using a standard short rate table. The **Policyholder** will send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

**Termination by Us**. **We** may terminate this **Policy** by giving the **Policyholder** at least thirty (30) days' notice of **Our** intent to terminate. Such notice will state the exact date the **Policy** will terminate. **We** may also end this **Policy** for non-payment of premium on any premium due date if the payment is not received prior to the end of the **Grace Period**. **We** will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records.

**B. Termination of Individual's Insurance.**

**Insured.** Insurance terminates at the end of the month for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. the **Insured** ceases to be eligible for insurance;
3. the **Insured** fails to pay the required premium, if the **Insured** is so required;
4. the **Insured** retires.

**Conversion Privilege**

If the insurance of an **Insured** ceases for reasons other than termination of the **Policy** or nonpayment of premium, the **Insured** is entitled to convert his or her **Coverage** to an **Individual Accidental Death or Dismemberment** (**IAD)** policy or to a **Family AD&D** (**FAD)** policy if the **Insured** selected a **Plan** covering his or her **Dependents**. The new **IAD** policy will be on approved forms and will not include all the **Benefits** and **Additional Benefits** of the Group **Accident Policy**. The **Insured** must make a written application for the **IAD** policy within sixty (60) days of the cessation of insurance under the Group **Accident Policy**. The **Insured** does not have to show proof of good health. To request a Conversion Application Form, the **Insured** must call 1-800-834-1959. The **Insured** does not have to show proof of good health.

The issuance of the **IAD** policy is subject to the following conditions:

1. the **Principal Sum** for the **IAD** policy will be the lesser of the **Insured's Principal Sum** under the Group **Accident Policy** or $100,000;
2. the premium for the **IAD** policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. any **IAD** policy issued will take effect on the termination date of the **Insured's** insurance under the Group **Accident Policy**; and
4. when an **IAD** policy becomes effective, the relationship between the **Insured** and **Us** will be governed by that policy, including all terms and conditions, and benefits and termination dates.

The **Conversion Privilege** will cease when the **Insured** attains age 70.

## SECTION X - HOW TO FILE A CLAIM

**A. Notice.** The **Insured** or the beneficiary, or someone on their behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. The notice must name the **Covered Person** who sustained the **Injury**, the **Insured**, and the **Policy** Number. To request a claim form, the **Insured** or the beneficiary, or someone on their behalf may contact **Us** at 1-866-841-4771. The notice must be sent to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

**B. Claim Forms. We** will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss.**

**C. Proof of Covered Loss.** Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss,** and the proof was provided as soon as reasonably possible.

## SECTION XI - PAYMENT OF CLAIMS

**A. Time of Payment. We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

**B. Who We Will Pay.**

1. Loss of Life of an **Insured**. **Covered Losses** resulting from the **Insured's** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as the **Insured**, **We** will pay the benefit to the beneficiary named by the **Insured** for the **Policyholder's** Group Life Insurance policy. If there is no beneficiary named by the **Insured** for the **Policyholder's** Group Life Insurance policy, or the named

beneficiary predeceases or dies at the same time as the **Insured**, **We** will pay the benefit to the **Insured's** survivors in the following order:

**a.** the **Insured's** legally married **Spouse** or **Domestic Partner**;

**b.** the **Insured's Child(ren);**

**c.** the **Insured's** parents;

**d.** the **Insured's** brothers and sisters;

**e.** the **Insured's** estate.

**2.** Loss of Life of a **Covered Person** other than the **Insured**. **Covered Losses** for the death of a **Covered Person** other than the **Insured** will be paid to the **Insured**. If the **Insured** pre-deceases or dies at the same time as the **Covered Person** other than the **Insured**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to the **Insured's** estate.

**3.** All Other Claims. Benefits are to be paid to the **Covered Person**.

**C. Physical Examination and Autopsy. We** have the right to examine an **Covered Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

**D. Choice of Service Provider.** The **Covered Person** has the sole right to choose his or her duly licensed physician and hospital.

## SECTION XII - GENERAL POLICY CONDITIONS

**A. Beneficiaries.** The **Insured** has the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. The **Insured** may change the beneficiary at any time unless he or she has assigned the interest in the **Policy**. In such case, the person to whom he or she has assigned the interest in this **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us.**

**B. Change or Waiver.** A change or waiver of any terms or conditions of this **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under this **Policy** will not be deemed as a waiver of such rights in the same or future situations.

**C. Clerical Error.** A clerical error or omission will not increase or continue an **Insured's Coverage**, which otherwise would not be in force. If an **Insured** applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.

**D. Conformity with Statute.** Terms of this **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

**E. Entire Contract.** This **Policy**, the **Policyholder** application, **Insured** enrollment materials, and any attachments represent the entire insurance contract between the **Policyholder** and **Us**.

**F. Grace Period.** Premiums are due for this **Policy** on or before the premium due date or renewal date, whichever applies. If the **Policyholder** does not pay a renewal premium when it is due, there is a thirty-one (31) day **Grace Period** to pay. During the **Grace Period**, the **Policy** will stay in force. The **Policyholder** will not have a **Grace Period** if **We** have given notice, at least thirty (30) days in advance, that **We** are going to terminate this **Policy**.

**G. Insured Certificates. We** will give to the **Policyholder** a **Certificate,** in either paper or electronic format, for their **Insureds,** where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Insureds**. Such **Certificate** will contain a summary of terms that affect benefits.

**H. Policyholder Records.** The **Policyholder** will keep a record of the **Coverage**, premium and other pertinent administrative information for each **Insured**, which, if acceptable to **Us** will be deemed to be a part of the **Policy**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured**. The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function.

**I. Suit Against Us.** No action on this **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Insured** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

**J. Renewal.** This **Policy** will automatically renew for an additional twelve-month period unless either party expresses its intent not to renew as specified by **Policy** termination provisions.

**K. ERISA Claims Fiduciary.** The **Policyholder** agrees that the **Policy** constitutes the plan and plan document under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The **Policyholder** designates **Us** as the claims fiduciary of this plan and gives **Us** the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The **Policyholder** agrees to comply with the disclosure and reporting requirements of ERISA regarding the plan and **Our** designation and authority as the claims fiduciary.

**L. Assignment of Interest.** A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.

**M. Newly Acquired Aircraft.** If the **Policyholder** acquires ownership or possession under a lease agreement of additional aircraft, and the **Policyholder** notifies **Us** of such acquisition or possession within three hundred and sixty-five (365) days after the delivery of the **Newly Acquired Aircraft**, the aircraft **Coverage** provided in Section IV – **Coverages** will also apply to the **Newly Acquired Aircraft** upon delivery of such aircraft to the **Policyholder**.

If the **Policyholder** does not notify **Us** of a **Newly Acquired Aircraft** within three hundred and sixty-five (365) days after its delivery, or does not pay the additional premium required, if any, **Coverage** for the **Newly Acquired Aircraft** will terminate. However, the **Policyholder** will be liable for the payment of any premium required for the period such **Coverage** was in effect.

**N. Newly Acquired Corporation** If the **Policyholder** acquires a corporation through stock purchase, exchange of stock or otherwise, and notifies **Us** of such acquisition within ninety (90) days thereafter, the eligible employees of the **Newly Acquired Corporation** will be insured under this **Policy** as of the effective date of such acquisition.

If the **Policyholder** does not notify **Us** and provide **Us** with the underwriting information necessary for **Us** to determine the amount of additional premium required, if any, within the ninety (90) days, or does not pay such additional premium, if any, as required, the **Coverage** for the employees of the **Newly Acquired Corporation** will terminate. However, the **Policyholder** will be liable for the payment of any premium required for the period such **Coverage** was in effect.

**Occidental Petroleum Corporation**
**GTU 7781876**
**Effective: January 1, 2022**

# Expanded Coverage

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

| THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY. | |
|---|---|
| Policy No. 7781876 | Effective Date: January 1, 2022 |

**THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Group Accident Policy.

It is agreed that:

The following is added to **SECTION II – SCHEDULE** of the **Policy**/Certificate:

| **ADDITIONAL BENEFITS:** | **Classes Covered** |
|---|---|
| Surgical Reattachment Benefit | ALL |
| Expanded Death Benefit | ALL |

The following are added to **SECTION VI – ADDITIONAL BENEFITS** of the **Policy**/Certificate:

**SURGICAL REATTACHMENT BENEFIT**

If a **Covered Person** suffers a **Covered Injury** requiring surgical reattachment of a severed arm, leg, hand or foot, **We** will pay the benefit listed in the Surgical Reattachment Table.

To be eligible for the Surgical Reattchment Benefit:

1. the surgical reattachment must occur within 365 days after the date of the **Covered Injury**;
2. be a **Surgical Rettachment Loss**; and
3. result in **Reattachment Medical Expenses.**

Surgical Reattachment Table

For loss of:

Both Legs or Both Arms ..... 50% of **Principal Sum**

Both Hands or Both Feet ..... 50% of **Principal Sum**

One Arm and One Leg ..... 50% of **Principal Sum**

One Hand and One Foot ..... 50% of **Principal Sum**

Either Leg or Arm ..... .25% of **Principal Sum**

Either Hand or Foot ..... .25% of **Principal Sum**

Thumb and Index Finger of Same Hand ..... 10% of **Principal Sum**

Maximum – All **Surgical Reattachment Losses** – per **Covered Injury** ..... 50% of **Principal Sum**

For this benefit only, the following definitions apply:

**Hospital** means a health care facility that meets all of the following requirements:

1. holds a license as a hospital, if required;
2. operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
3. provides twenty-four (24) hour a day nursing service by registered nurses;
4. has a staff of one or more **Physicians** available at all times;
5. has facilities for diagnosis, and major medical surgical facilities; and
6. is not primarily a clinic, nursing, rest or convalescent home or similar establishment, nor is not, other than incidentally, a substance abuse center or halfway house.

**Physician** means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that **We** recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given;
3. practicing within the scope of that license referenced in 2. above.

**Reattachment Medical Expenses** means the following associated costs and/or expenses if required due to a **Surgical Reattachment Loss**:

1. medical treatment by a **Physician** or surgeon, acting within the scope of his or her license;
2. services of a licensed anesthesiologist, acting within the scope of his or her license;
3. services of a licensed nurse, acting within the scope of his or her license; and
4. **Hospital** confinement.

**Surgical Reattachment Loss** means:

1. loss of a leg by total severance at or above the knee proximal to the hip;
2. loss of an arm by total severance at or above the elbow proximal to the shoulder;
3. loss of a hand by total severance at or above the wrist proximal to the elbow;
4. loss of a foot by total severance at or above the ankle joint proximal to the knee;
5. loss of thumb and index finger by total severance at or above the knuckles proximal to the wrist.

This benefit is subject to the limitations in Section VIII General Limitations.

**EXPANDED DEATH BENEFIT**

If a **Covered Person** suffers a loss of life as a result of a **Covered Injury**, **We** will pay an Expanded Death Benefit of $5,000.

To qualify for the Expanded Death Benefit, the loss of life must occur within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VIII - General Limitations.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy**/Certificate to which it is attached.

AMENDATORY ENDORSEMENT
**Administrative Change**

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

This endorsement, effective January 1, 2022, forms a part of **Policy** No. GTU 7781876, issued to Occidental Petroleum Corporation.

**AMENDMENT TO POLICY DEFINITIONS**

I. It is hereby understood and agreed that effective January 1, 2022 the definition of **Dependent Child(ren)** is amended to the following and replaces any definition of **Dependent Child(ren)** that currently exists in the **Policy**:

> **Dependent Child(ren)**, if used in this policy, means natural children; children legally adopted or placed for adoption with the **Insured** Person, stepchildren, foster children; and other children who you claim as dependents on your federal income tax return for whom you and/or your spouse have primary legal custody and who live with you in a regular parent/child relationship.
>
> To be eligible, children must be under 26 years of age.
>
> Attainment of the age limit shall not terminate coverage of any covered child who is and continues to be (a) unable to earn a living because of mental retardation or physical handicap; and (b) dependent upon the **Insured** Person for support and maintenance.

II. It is also hereby understood and agreed that effective January 1, 2022 the definition of **Spouse** is amended to the following and replaces any definition of **Spouse** that currently exists in the **Policy**:

> **Spouse**, if used in this **Policy,** means to whom the **Insured** Person is legally married or the **Domestic Partner** of an **Insured** Person. All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which the **Insured** Person resides. This includes a spouse through common law marriage in applicable states. This does not include a spouse from whom the **Insured** Person is legally separated.

III. It is also hereby understood and agreed that effective January 1, 2022 the definition of **Domestic Partner** is amended to the following and replaces any definition of **Domestic Partner** that currently exists in the **Policy**:

> **Domestic Partner** means each of two people, one of whom is an **Insured** Person, who:
>
> a) have registered as each other's **Domestic Partner**, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
> b) are of the same sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
>
> 1. 18 years of age or older;
> 2. unmarried;
> 3. the sole **Domestic Partner** of the other;
> 4. sharing a primary residence with the other; and
> 5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.
>
> A **Domestic Partner** declaration attesting to the existence of an insurable interest in one another's lives must be completed and signed by the **Insured** Person.

Except for the above, this Amendatory Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Endorsement No. As issued with Policy

Signed for by Zurich American Insurance Company  Date: January 1, 2022

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION**

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law if found in the *Texas Insurance Code,* Article 21.28-D.)

**BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.**

**Eligibility for Protection by the Association**

When an insurance company which is a member of the Association is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- **residents of Texas** at the time that their insurance company is impaired;
- **residents of other states,** ONLY if the following conditions are met:
    1) the policyholder has a policy with a company based in Texas;
    2) the policyholder's state of residence has a similar guaranty association; and
    3) the policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

**Limits of Protection by the Association**

**Accident, Accident and Health, or Health Insurance:**

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

**Life Insurance:**

- Net cash surrender value or net cash withdrawal value up to a total of $100,000, under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

**Individual Annuities:**

- Present value of benefits up to a total of $250,000 under one or more policies on any one life.

**Group Annuities:**

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contract holder regardless of the number of contracts.

**Aggregate Limit:**

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 unallocated group annuity limit.

**Government Plans:**

- Present value annuity benefits, in aggregate, up to a total of $250,000 including net cash surrender and net cash withdrawal values for individuals in a plan established under sections 401, 403(b), and 457 of the Internal Revenue code.

These limits are applied for each insolvent insurance company.

**THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSES OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.**

**When you are selecting an insurance company, you should not rely on coverage by the Association. For additional questions on Association protection or general information about an insurance company, please use the following contact information.**

Texas Life, Accident, and Health
Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, TX 78701
(800) 982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
(800) 252-3439 or www.tdi.texas.gov

# SANCTIONS EXCLUSION ENDORSEMENT

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY**

The following exclusion is added to the policy to which it is attached and supersedes any existing sanctions language in the policy, whether included in an Exclusion Section or otherwise:

SANCTIONS EXCLUSION

Notwithstanding any other terms under this policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any insured, beneficiary, or third party who may have any rights under this policy to the extent that such coverage, payment, service, benefit, or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

The term policy may be comprised of common policy terms and conditions, the declarations, notices, schedule, coverage parts, insuring agreement, application, enrollment form, and endorsements or riders, if any, for each coverage provided. Policy may also be referred to as contract or agreement.

We may be referred to as insurer, underwriter, we, us, and our, or as otherwise defined in the policy, and shall mean the company providing the coverage.

Insured may be referred to as policyholder, named insured, covered person, additional insured or claimant, or as otherwise defined in the policy, and shall mean the party, person or entity having defined rights under the policy.

These definitions may be found in various parts of the policy and any applicable riders or endorsements.

**ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED**

# *Privacy Notice*

## *We Take Important Steps to Protect the Nonpublic Personal Information We Collect About You*

***Dear Customer:*** ***rev. January 2020***

We care about your privacy. That is why we believe in your right to know what nonpublic personal information ("NPI") we collect about you and what we do with that information. This Privacy Notice describes the NPI we collect about you and how we share and protect that information.

| **Overview** | UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION |
|---|---|

| | |
|---|---|
| **Why are you receiving this Notice?** | Financial institutions, which include the Company, choose how they share your NPI. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your NPI. You are receiving this Privacy Notice because our records show either that you are a customer who is obtaining or has obtained insurance coverage or non-insurance products or services. |

| | |
|---|---|
| **What types of Information do we collect?** | The types of NPI we collect depend on the product or service you have with us. This information can include:<br><br>• Information about you we receive on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, driver's license number, employment information, information about your income, assets and net worth, and medical information;<br>• Information about your transactions with the Company and its affiliates;<br>• Information about your insurance coverage, premiums, claims history, and payment history;<br>• Data from insurance support organizations, government agencies, insurance information sharing bureaus;<br>• Property information and similar data about you or your property, such as property appraisal reports; and<br>• Information we receive from a consumer reporting agency or insurance information sharing bureau, such as a credit or fraud report.<br><br>When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice. |

| | |
|---|---|
| **What do we do with the NPI we collect?** | We share your NPI in the course of supporting your insurance coverage or non-insurance products or services, as authorized by law, or with your consent. This includes sharing, as permitted by law, your NPI with affiliated parties and nonaffiliated third parties, as applicable, in the course of supporting your insurance coverage or non-insurance products.<br><br>These affiliates and nonaffiliated third parties include:<br>• Financial service providers, such as banks and other insurance companies;<br>• Non-financial companies, such as medical providers and nonaffiliated service providers that perform marketing services on our behalf; and<br>• Others, such as consumer reporting agencies and insurance information sharing bureaus.<br><br>In the section below, we list the reasons we can share your NPI, whether we actually share your NPI, and whether you can opt out of this sharing (or if you are a resident of Vermont, whether you have the right to opt in to allowing this sharing). |

| Reasons we can share your personal information | Does Company Share? | Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing? |
|---|---|---|
| **For our everyday business purposes** – such as to process your transactions, administer insurance coverage, products or services, maintain your account, prevent fraud and 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** | No | Not Applicable |
| **For our affiliates' everyday business purposes** – transaction and experience information | Yes | No |
| **For our affiliates' everyday business purposes** – information about your creditworthiness | No | Not Applicable |
| **For our affiliates to market to you** | Yes | No |
| **For non-affiliates to market their products to you** | No | Not Applicable |

| **Collecting and safeguarding information** | |
|---|---|
| **How often do you notify me about your privacy practices?** | We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision. Please review the privacy policy posted on our website, ZurichNA.com. It contains additional information about our practices. |
| **Why do you collect my NPI?** | We collect NPI when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. Information in a report prepared by an insurance support organization may be retained by that organization and provided to others. |
| **What NPI do we share?** | We may provide to affiliates and/or nonaffiliated third parties the same NPI listed above in the section entitled, "What types of information do we collect?" |
| **How do you safeguard my NPI?** | Employees who have access to your NPI are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards. |

**FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:**

**You have the following individual rights under state law:**

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information, you must submit a request using our online form on our website, ZurichNA.com, or calling our toll-free number at 1-800-382-2150. You may also reasonably describe the information you seek in writing and send your written request to the Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information if it is permitted by law. If you request medical records, we may elect to supply that information to you through your designated medical professional for security purposes. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once through any of the above methods, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You may make your request using any of the above methods.

Residents of California and Nevada have additional rights over their non-public personal information if it is not governed by the Gramm-Leach-Bliley Act. For more information about these rights, please consult our online privacy policy posted on our website, ZurichNA.com.

**FOR RESIDENTS OF MASSACHUSETTS ONLY WHO ARE ZNA P&C CUSTOMERS:** You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

| **Key words and phrases** | TERMS YOU SHOULD KNOW |
|---|---|

| **Definitions** | |
|---|---|
| **Everyday business purposes** | The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as:<br>• Processing transactions, mailing and auditing services;<br>• Administering insurance coverage, product, services or claims;<br>• Providing information to credit bureaus;<br>• Protecting against fraud;<br>• Responding to court/governmental orders or subpoenas and legal investigations; and<br>• Responding to insurance regulatory authorities. |
| **Affiliates** | Financial or nonfinancial companies related by common ownership or control.<br>• *Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.* |

| | |
|---|---|
| **Nonaffiliated Third Parties** | Financial or nonfinancial companies not related by common ownership or control. We may share your information with companies that we hire to perform marketing and business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we share information with others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the services.<br>• *The Company does not share information with nonaffiliates to market their products to you*. |
| **Joint marketing** | A formal agreement between nonaffiliated financial companies that together market financial products or services to you.<br>• *The Company does not jointly market.* |

| | |
|---|---|
| **Changes to this Privacy Notice; contact us** | We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes.<br><br>If you have any questions about your contract with us, you should contact your agent.<br><br>If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. |

This Privacy Notice is sent on behalf of the following affiliated companies, which are referred to in this Privacy Notice, in the aggregate, as the "Company:"

*American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (together, "the ZNA P&C Companies"), Zurich American Life Insurance Company, and Zurich American Life Insurance Company of New York*.

# Texas Important Notice

## Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company 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. If you don't, you may lose your right to appeal.

**Zurich North America**
To get information or file a complaint with your insurance company

**Call: Customer Inquiry Center at 1-847-413-5438**

**Toll-free: 1-800-382-2150**

Email: info.source@zurichna.com
Mail: 1299 Zurich Way, Schaumburg, IL 60196-1056

**The Texas Department of Insurance**
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC111-1A, P.O. Box 149091, Austin, TX 78714-9091

## ¿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. 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. Si no lo hace, podría perder su derecho para apelar.

**Zurich North America**
Para obtener información o para presentar una queja ante su compañía de seguros:

**Llame a: Customer Inquiry Center at 1-847-413-5438**

**Teléfono gratuito: 1-800-382-2150**

Correo electrónico: info.source@zurichna.com
Dirección postal: 1299 Zurich Way, Schaumburg, IL 60196-1056

**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

# Certificate of Insurance

ZURICH

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

Having issued **Accident Policy** Number GTU 7781876 to cover the eligible individuals of:

**Occidental Petroleum Corporation**

The insurance evidenced by this **Certificate** provides **ACCIDENT** insurance only. It does not provide **Coverage** for sickness. This **Certificate** describes the main features of the **Policy**, but the **Policy** is the only contract under which benefit payments are made. If there is an inconsistency between the **Certificate** and the **Policy**, the **Policy** will govern.

## IMPORTANT NOTICE

**THIS INSURANCE PROVIDES ACCIDENT COVERAGE ONLY**
**THIS INSURANCE DOES NOT PROVIDE BENEFITS FOR SICKNESS**

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## SECTION I – ELIGIBILITY AND EFFECTIVE DATES

**CERTIFICATEHOLDER:**

**Class I:**

1) All regular full-time non-bargaining hourly or salary Employees regularly scheduled to work at least twenty (20) hours per week on U.S. Dollar Payroll of Occidental Petroleum Corporation or an **Affiliated Company** (Oxy). Temporary Employees and Employees of certain **Affiliated Companies** designated by Oxy are not eligible to participate. An **Affiliated Company** means any company in which 80 percent or more of the equity interest is owned by Occidental Petroleum Corporation. Employees who are part of a collective bargaining group are eligible to participate in the Plan only if the negotiated bargaining agreement specifically provides for participation.

2) Part-time Non-bargaining hourly or salary Employees who are eligible for retiree medical coverage (at least age 60 and 10 or more years of regular full-time service).

3) All **Active** Employees represented by United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO, Local 620 (Geismar, LA)

4) All **Active** Employees represented by The International Union of Operating Engineers, AFL-CIO, Local 119 (Wichita, KS)

5) Disabled individuals who are eligible to continue their AD&D coverage, as originally issued under policy GTU 8364499 issued by Zurich American Insurance Company, through the duration of their Long-Term Disability (LTD) claim approval, whose names are on file with the Company.

If an **Insured** suffers an **Injury** resulting in a **Covered Loss,** and he or she is covered under more than one class, **We** will pay only one benefit, the largest benefit.

**ELIGIBILITY OF YOUR DEPENDENTS:**

Individuals who enroll may elect to cover their eligible **Dependents.** An eligible **Dependent** includes the **Insured's** legally married **Spouse**/**Domestic Partner** and the **Insured's Dependent Child(ren)**. A legally married **Spouse**/**Domestic Partner** will not be eligible as a **Dependent** if he or she is also an **Insured** under this **Policy**. If the **Insured** and his or her legally married **Spouse**/**Domestic Partner**, legally separated **Spouse**/**Domestic Partner,** former **Spouse**/**Domestic Partner** are both **Insured's** under this **Policy**, only one may select a **Plan** covering their mutual **Dependents**.

**YOUR EFFECTIVE DATE OF INSURANCE:**

A. For eligible individuals hired prior to January 1, 2022:
The **Policy** effective date.

B. For eligible individuals hired on or after January 1, 2022:
The date of hire.

## SECTION II – SCHEDULE

| **COVERAGES(S):** | **Classes Covered** |
|---|---|
| 24 Hour **Accident** Protection, Business and Pleasure, Including Corporate Owned or Leased Aircraft, and Substitute Aircraft, Passenger and Crew, H-1 | All |
| Exposure and Disappearance Coverage | All |
| War Risk Coverage | All |

**BENEFITS:** **Classes Covered**

**ACCIDENTAL DEATH BENEFIT** All

**Principal Sum**:

**Class I:**

1) An amount equal to one (1) to ten (10) times the employee's **Base Annual Earnings*** subject to a minimum of $10,000 and a maximum of $1,500,000 rounded to the next higher even multiple of $10,000, if not already an even multiple of $10,000.

2) An amount equal to one (1) to ten (10) times the employee's **Base Annual Earnings* s**ubject to a minimum of $10,000 and a maximum of $1,500,000 rounded to the next higher even multiple of $10,000, if not already an even multiple of $10,000

3) $5,000, $10,000 or $15,000

4) $5,000, $10,000 or $15,000

5) As on file with the Company.

***** **Base Annual Earnings** means:

1. For exempt employees, base pay defined as only the employee's regular salary.
2. For non-exempt employees, base pay defined as only the employee's scheduled straight time hourly wages and regularly scheduled overtime.
3. For exempt and non-exempt employees, earnings excludes bonuses, unscheduled overtime, geographic premiums, other premiums, or additional forms of compensation.

The **Principal Sum** for **Covered Dependents** will be the following amounts:

**Spouse/Domestic Partner**: 100% or 50% of the **Insured's Principal Sum**

**Dependent Child(ren)**: $20,000

In no event will the amount be greater than the **Insured's Principal Sum**

**Classes Covered**

**ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE AND PLEGIA BENEFIT** All

**Principal Sum**:

Same as above.

| **ADDITIONAL BENEFITS:** | **Classes Covered** |
|---|---|
| Continuation of Insurance Benefit | All |
| Critical Burn Benefit | All |
| Day Care Benefit | All |
| Felonious Assault Benefit | All |
| Higher Education Benefit | All |
| Home Alteration And Vehicle Modification Benefit | All |
| Rehabilitation Benefit | All |
| Seat Belt/Air Bag Benefit | All |
| Spouse/Domestic Partner Retraining Benefit | All |
| Therapeutic Counseling Benefit | All |
| Travel Assistance Plan | All |

| ADDITIONAL ENDORSEMENTS | Form Number | Classes Covered |
|---|---|---|
| Expanded Coverage | U-VA-207-A CW (09/21) | All |

## SECTION III – DEFINITIONS

**Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

**Active** and **Actively at Work** describes **You** if **You** are able and available for active performance of all of **Your** regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered **Actively at Work** provided **You** are able and available for active performance of all of **Your** regular duties and were working the day immediately prior to the date of **Your** absence.

**Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the Schedule. For purposes of the **Aggregate Limit of Liability** provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the **Aggregate Limit of Liability** is not enough to pay full benefits to each **Covered Person**, **We** will pay each one a reduced benefit based upon the proportion that the **Aggregate Limit of Liability** bears to the total benefits which would otherwise be paid.

**Certificate** means this **Certificate** for the **Group Accident Insurance Policy.**

**Chartered Aircraft** means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than ten (10) consecutive days and/or for no more than fifteen (15) days in a one (1) year period.

**Controlled** by, as used in the **Coverages** Section, means the **Policyholder** has the right to use a block of aircraft flight time for 25 or more hours in a one (1) year period or for 100 hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.

**Coverage(s)** means the event or events described in the **Hazards** of the **Policy** to which benefits and additional benefits apply. The **Hazards** are listed in the **Coverages** Section on the Schedule.

**Covered Accident** means an **Accident** that results in a **Covered Loss**.

**Covered Injury** means an **Injury** directly caused by accidental means, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under the **Policy**, and results in a **Covered Loss**.

**Covered Loss** means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury,** and for which benefits are payable under the **Policy**.

**Covered Person** means any person who has insurance under the terms of the **Policy**. It includes **You**, and **Your Spouse/Domestic Partner** and/or **Dependent Child(ren)** if **You** select a **Plan** covering **Your Spouse/Domestic Partner** and/or **Dependent Child(ren)**.

**Dependent** means **Your Spouse**/**Domestic Partner** and **Dependent Child(ren),** as defined in this section. The **Dependent** will only be a **Covered Dependent** if a **Plan** covering **Dependents** is selected.

**Dependent Child(ren)**, if used in this policy, means natural children; children legally adopted or placed for adoption with the **Insured** Person, stepchildren, foster children; and other children who you claim as dependents on your federal income tax return for whom you and/or your spouse have primary legal custody and who live with you in a regular parent/child relationship.

To be eligible, children must be under 26 years of age.

Attainment of the age limit shall not terminate coverage of any covered child who is and continues to be (a) unable to earn a living because of mental retardation or physical handicap; and (b) dependent upon the **Insured** Person for support and maintenance.

**Domestic Partner** means each of two people, one of whom is an **Insured** Person, who:

a) have registered as each other's **Domestic Partner**, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
b) are of the same sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
    1. 18 years of age or older;
    2. unmarried;
    3. the sole **Domestic Partner** of the other;
    4. sharing a primary residence with the other; and
    5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A **Domestic Partner** declaration attesting to the existence of an insurable interest in one another's lives must be completed and signed by the **Insured** Person.

**Injury** means a bodily **Injury** .

**Insured** means an individual who is eligible for **Coverage** under the **Policy** as provided in the Certificateholder part of the **Eligibility and Classification of Insureds** Section, and who completes the enrollment material, if required.

**Owned Aircraft** means an aircraft in which the **Policyholder** or a related company has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.

**Plan** means the **Plan** design as described on the **Schedule**.

**Policy** means the Group **Accident** Insurance **Policy**.

**Policyholder** means the group named on the front page of the **Policy**.

**Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:

acrobatic or stunt flying
banner towing
bird or fowl herding
crop dusting
crop seeding
crop spraying
endurance tests
fire fighting
flight on a rocket-propelled or rocket launched aircraft
flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted
hang gliding
hunting
parachuting or skydiving
racing
skywriting
test or experimental purpose

**Spouse**, if used in this **Policy,** means to whom the **Insured** Person is legally married or the **Domestic Partner** of an **Insured** Person. All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which the **Insured** Person resides. This includes a spouse through common law marriage in applicable states. This does not include a spouse from whom the **Insured** Person is legally separated.

**Under lease**, as used in the **Coverages** Section, means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than ten (10) consecutive days and/or for more than fifteen (15) days in a one (1) year period. A **Chartered Aircraft** will not be considered **Under lease**.

**We, Us,** and **Our** refers to Zurich American Insurance Company.

**You**, **Your** refers to the **Insured**.

## SECTION IV – COVERAGES

**24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE INCLUDING CORPORATE OWNED OR LEASED AIRCRAFT, AND SUBSTITUTE AIRCRAFT, PASSENGER AND CREW, H-1**

The **Hazards** insured against by the **Policy** are:

A **Covered Injury** sustained by a **Covered Person** anywhere in the world, subject to the terms, conditions, exclusions and limitations under the **Policy**.

**Hazard Limitations:**

Air travel **Coverage** is limited to a loss sustained during a trip, while the **Covered Person** is a passenger, riding in or on, boarding or getting off:

**A.** any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government.

This aircraft must be operated by a pilot with a current and valid:

**1.** medical certificate; and

**2.** pilot certificate with a proper rating to pilot such aircraft

**B.** any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

**Hazard Exclusions:**

**Coverage** is not provided:

**A.** If the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft except those specified below. Or

**B.** Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:

**1.** any aircraft other than those expressly stated in this **Coverage**;

**2.** any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder** except the following aircraft, including **Substitute Aircraft**

As on File with the **Policyholder**

provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft.

**3.** any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured** or a member of a **Covered Person's** family or household;

**4.** any aircraft operated by the **Policyholder** or one of the **Policyholder's** employees including members of an employee's family or household;

**5.** any aircraft engaged in a **Specialized Aviation Activity**;

**6.** any conveyance used for tests or experimental purposes, or in a race or speed test.

**Hazard Definitions:**

**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:

1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
2. is the same class of aircraft as the specified aircraft; and
3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

**EXPOSURE AND DISAPPEARANCE COVERAGE**

If a **Covered Person** is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which a **Covered Person** is riding disappears, is wrecked, or sinks, and the **Covered Person** is not found within 365 days of the event, **We** will presume that the **Covered Person** lost his or her life as a result of **Injury**. If travel in such conveyance was covered under the terms of the **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the **Covered Person** survived the event.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

**WAR RISK COVERAGE**

The exclusion for war or any acts of war, whether declared or undeclared, as found in Section VII General Exclusions of this **Certificate,** is modified and **Covered Injuries** directly resulting from war or any acts of war are covered under the **Policy** provided:

**A.** the **Injury** does not result from war or any acts of war, whether declared or undeclared, occurring within any of the states of the United States of America (including the District of Columbia), Afghanistan, Iraq, or the **Covered Person's** country of residence.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

## SECTION V – BENEFITS

**ACCIDENTAL DEATH BENEFIT**

If a **Covered Person** suffers a loss of life as a result of a **Covered Injury**, **We** will pay the applicable **Principal Sum**. The death must occur within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VIII General Limitations.

**ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT**

If an **Injury** to a **Covered Person** results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

| **Covered Loss** of | **Benefit** |
|---|---|
| **1.** Both Hands or Both Feet | **Principal Sum** |
| **2.** One Hand and One Foot | **Principal Sum** |
| **3.** One Hand or One Foot plus the loss of Sight of One Eye | **Principal Sum** |
| **4.** Sight of Both Eyes | **Principal Sum** |
| **5.** Speech and Hearing | **Principal Sum** |
| **6.** Speech or Hearing | 50% of **Principal Sum** |
| **7.** One Hand; One Foot; or Sight of One Eye | 50% of **Principal Sum** |
| **8.** Thumb and Index Finger of the same Hand | 25% of **Principal Sum** |
| **9.** Hearing in One Ear | 25% of **Principal Sum** |

| **Covered Loss of Use** of | |
|---|---|
| **1.** Four **Limbs** | **Principal Sum** |
| **2.** Three **Limbs** | 85% of **Principal Sum** |
| **3.** Two **Limbs** | 75% of **Principal Sum** |
| **4.** One **Limb** | 50% of **Principal Sum** |

For purposes of this benefit:

1. **Covered Loss** means:
   - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
   - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
   - **c.** Total and permanent loss of sight;
   - **d.** Total and permanent loss of speech;
   - **e.** Total and permanent loss of hearing.
2. **Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which has continued for 12 consecutive months and is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.

This benefit is subject to the limitations in Section VIII General Limitations.

**ACCIDENTAL DISMEMBERMENT AND LOSS OF USE BENEFIT FOR COVERED DEPENDENT CHILDREN**

If an **Injury** to a **Covered Dependent Child(ren)** results in any of the following **Covered Losses**, **We** will pay the benefit shown. The **Covered Loss** must occur within 365 days of the **Accident**.

| **Covered Loss** of | **Percentage** of **Your Principal Sum** |
|---|---|
| **1.** Both Hands or Both Feet | 200% to a maximum of $40,000 |
| **2.** One Hand and One Foot | 200% to a maximum of $40,000 |
| **3.** One Hand or One Foot plus the loss of Sight of One Eye | 200% to a maximum of $40,000 |
| **4.** Sight of Both Eyes | 200% to a maximum of $40,000 |
| **5.** Speech and Hearing | 200% to a maximum of $40,000 |
| **6.** Speech or Hearing | 100% to a maximum of $20,000 |
| **7.** One Hand; One Foot; or Sight of One Eye | 100% to a maximum of $20,000 |
| **8.** Thumb and Index Finger of the same Hand | 50% to a maximum of $10,000 |
| **9.** Hearing in One Ear | 50% to a maximum of $10,000 |
| **Covered Loss of Use** of | |
| **1.** Four **Limbs** | 200% to a maximum of $40,000 |
| **2.** Three **Limbs** | 170% to a maximum of $34,000 |
| **3.** Two **Limbs** | 150% to a maximum of $30,000 |
| **4.** One **Limb** | 100% to a maximum of $20,000 |

For purposes of this **Benefit**:

1. **Covered Loss** means:
   - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
   - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
   - **c.** Total and permanent loss of sight;
   - **d.** Total and permanent loss of speech;
   - **e.** Total and permanent loss of hearing.
2. **Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which has continued for twelve (12) consecutive months and is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.

This benefit is subject to the limitations in Section VIII General Limitations.

**COMA BENEFIT**

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** within 31 days of a **Covered Accident**, and such **Injury** causes the **Covered Person** to be in a **Coma** for at least sixty (60) consecutive days, **We** will pay a **Coma Benefit**.

The **Coma Benefit** is equal to 5% of the **Covered Person's Principal Sum**, and will be paid each month the **Covered Person** remains in a **Coma** following the initial sixty (60) day period. The **Coma Benefit** will end on the earliest of the following:

1. the **Covered Person** is no longer in a **Coma** which directly resulted from the **Injury**;
2. the **Covered Person** has received a **Coma Benefit** for 12 months.

**Coma** will be determined by **Our** duly licensed physician.

This benefit is subject to the limitations in Section VIII General Limitations.

## SECTION VI – ADDITIONAL BENEFITS

**CONTINUATION OF INSURANCE BENEFIT**

If **You**, selected a **Plan** covering **Your Dependents** and **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, all **Coverages** under the **Policy** which were in force on the date of the loss, with respect to **Covered Persons** other than **You**, will be continued automatically for 365 days after the date of the loss at no additional cost.

**CRITICAL BURN BENEFIT**

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** as a result of a **Covered Accident,** which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit,** an additional benefit will be payable equal to the lesser of 10% of the **Insured's Principal Sum** or $25,000, provided all terms and conditions of the **Policy** are met and:

1. the **Covered Person** has received second degree or higher burns over 25% of his or her body; and
2. the **Covered Person** has undergone reconstructive surgery to treat the burned areas of the body; and
3. the reconstructive surgery has taken place within 365 days of the occurrence of the **Injury**.

**DAY CARE BENEFIT**

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Spouse/Domestic Partner** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each **Dependent Child** if:

1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within ninety (90) days from the date of loss; and
2. the **Covered Dependent Child** is under age 13.

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the child care;
2. 5% of the **Covered Person's Principal Sum** who suffered the **Covered Loss**; or
3. $3,000.

If both **You** and **Your Covered Spouse/Domestic Partner** suffer a simultaneous **Covered Loss**, the **Day Care Benefit** will be based on **Your Principal Sum**.

The **Day Care Benefit** will be paid annually for four (4) consecutive years if:

1. the **Covered Dependent Child** is under age 13 at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

**FELONIOUS ASSAULT BENEFIT**

If **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit** or **Accidental Dismemberment and Covered Loss of Use Benefit** as a result of a violent or criminal act committed by someone other than **You**, a **Fellow Employee** or a member of **Your Family** or **Household**, **We** will pay an additional benefit equal to 10% of **Your Principal Sum**, provided:

1. the **Injury** is incurred in connection with the **Policyholder's** normal business whether on or off the **Policyholder's** premises; and
2. the crime directly involves the **Policyholder's** funds or assets.

For purposes of this benefit:

**Fellow Employee** means a person employed by the same employer as **You** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than forty-five (45) days prior to the date on which the defined violent crime/felonious assault was committed.

**Family** means **Your** parent, step-parent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

**Household** means a person who maintains residence at the same address as **You**.

This benefit applies only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.

**HIGHER EDUCATION BENEFIT**

If **You** selected a **Plan** covering **Your Dependent Child(ren)** and **You** suffer an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**.

A **Dependent Child** is eligible for the **Higher Education** benefit if on the date of the **Accident**:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she was at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The **Higher Education** will be equal to 5% of **Your Principal Sum**, to a maximum of $5,000. This amount will be paid annually for four (4) consecutive years if **Your Dependent Child** continues his or her education. Before this benefit is paid each year, **Your Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.

**HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT**

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, **We** will pay an additional benefit for home alterations and/or vehicle modifications, provided:

1. the **Covered Person** is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the **Injury** that caused the payment of the **Accidental Dismemberment and Covered Loss of Use Benefit** is the same **Injury** that requires the **Covered Person** to need the wheelchair.

The amount **We** will pay will be equal to:

1. the one time cost of alterations to the **Covered Person's** primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to his or her motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 5% of the **Covered Person's Principal Sum** or $10,000.

**REHABILITATION BENEFIT**

If **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training** in an amount equal to the lesser of:

1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the **Rehabilitation Training**;
2. $6,000; or
3. 10% of **Your Principal Sum**.

**Rehabilitation Training** means a treatment program that:

1. is prescribed by a licensed physician acting within the scope of his or her license that is approved by **Us** prior to the provision of services;
2. is required due to **Your Injury**; and
3. prepares **You** for an occupation which **You** would not have engaged in except for the **Injury**.

**Reasonable and Customary** expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

**We** reserve the right to make the final determination of what is **Reasonable and Customary**.

**SEAT BELT/AIR BAG BENEFIT**

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, **We** will pay an additional benefit, which equals 10% of the applicable **Principal Sum** up to a maximum of $50,000 provided that the **Covered Person** was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of the **Covered Person's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

An additional benefit equal to 5% of the **Covered Person's Principal Sum** to a maximum of $20,000, will be paid if the **Insured** was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the **Insured's** seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.

**We** will not pay a **Seat Belt** or **Air Bag Benefit** if the driver of the automobile in which the **Covered Person** was riding was either:

1. under the influence of alcohol;
   - **a.** A driver will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle.
   - **b.** An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.

**SPOUSE/DOMESTIC PARTNER RETRAINING BENEFIT**

If **You**, selected a **Plan** covering **Your Spouse/Domestic Partner**, and **You** suffer an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, **We** will pay to, or on behalf of, **Your Spouse/Domestic Partner**, the actual cost of any professional or trade-training program in which the **Spouse/Domestic Partner** enrolls, provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;
2. the actual cost is incurred within thirty (30) months from **Your** death; and
3. the professional or trade training program is licensed by the state.

The maximum amount payment under this benefit will be the lesser of 10% of **Your Principal Sum** or $20,000.

**THERAPEUTIC COUNSELING BENEFIT**

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Dependents** suffer an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit,** and **You** or **Your Covered Dependents** require **Therapeutic Counseling**, **We** will reimburse the actual expense for such counseling to the individual who incurs the expense, provided:

(1) all terms and conditions of the **Policy** are met;

(2) **Therapeutic Counseling** begins within ninety (90) days of the **Covered Accident**;

(3) **Therapeutic Counseling** must be incurred within one year from the date of the **Covered Loss**.

**Therapeutic Counseling** means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is $6,000 for any one **Covered Accident**.

**TRAVEL ASSISTANCE PLAN**

This **Travel Assistance Plan** will apply to the following **Covered Persons** when they are traveling 100 miles or more from their **Principal Residence**: the **Insured** and his or her **Spouse** (/**Domestic Partner**) and or **Child(ren)** if the **Spouse**/**Domestic Partner** and or **Child(ren)** are with the **Insured** while he or she is covered under this **Policy**. The **Spouse**/**Domestic Partner** or **Child(ren)** will not be covered while making a trip without the **Insured**. The transportation and/or services provided under this **Travel Assistance Plan** must be pre-authorized by **Us**. Under this **Policy,** the **Travel Assistance Plan** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

  **Medical Evacuation**

  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician.

  For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

  **Medical Repatriation**

  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to his or her **Principal Residence,** or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

**Non-Medical Repatriation**

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending physician. The upgrade will be subject to **Our** sole discretion.

**Return of Remains**

If a **Covered Person** dies while on a **Covered Trip, We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable.

**Visit to Hospital**

If a **Covered Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip, We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Covered Person** to visit the **Covered Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable.

**Return of Child**

If a **Covered Person** is traveling with a **Child(ren),** who is under nineteen (19) years of age or a **Child(ren)** who prior to age nineteen (19) became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Covered Person** for support and maintenance, while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Covered Person,** such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Covered Person,** and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable.

**Return of Companion**

If a **Covered Person** is traveling with a companion while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Covered Person** the **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable.

- **TRAVEL ASSISTANCE EXCLUSIONS**

**We** will not provide the **Travel Assistance Plan** if the **Coverage** is excluded under Section VII – General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the **Covered Person** being under the influence of any controlled substance, unless such controlled substance was prescribed by a physician and was taken in accordance with the prescribed dosage;
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Covered Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Covered Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or MEDICAL REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services;

- **TRAVEL ASSISTANCE DEFINITIONS**

  For purposes of this **Travel Assistance Plan** only, the following definitions apply:

  **"Covered Trip"** means when a **Covered Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

  **"Illness"** or **"Ill"** means a sickness or disease which impairs normal functions of the body.

  **"Injured" "Injury"** or **"Injuries"** means a bodily **Injury** or **Injuries** and is not limited to accidental bodily injuries.

  **"Principal Residence"** means the legal domicile of the **Covered Person.**

  **"Western Medical Standards"** means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.

  For the purpose of the **Travel Assistance Plan**, if there are any differences in the definition of a term between the **Travel Assistance Plan** and the **Policy,** the definition in the **Travel Assistance Plan** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

  **Right of Recovery**

  **We** have the right to recover any benefits that **We** have paid under this **Travel Assistance Plan** if the **Policyholder** or **Covered Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Covered Person** that were covered under this **Travel Assistance Plan. We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Covered Person** for transportation services and/or expenses, which were not covered under the **Travel Assistance Plan.**

  **Reservation of Rights**

  **We** reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services.

  **Scope**

  **Illness**, as covered under this **Travel Assistance Plan,** is solely covered under this **Travel Assistance Plan,** and in no way supercedes or modifies the other **Coverages** provided under this **Policy**.

To contact **Us** regarding this **Travel Assistance Plan**, the **Covered Person** must call 1-800-263-0261 from the U.S. or Canada; and collect from anywhere else in the world at +1-416-977-0277.

## SECTION VII – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service. Reserve or National Guard active duty training is not excluded, unless it extends beyond sixty (60) consecutive days;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony;
6. being intoxicated while operating a motor vehicle.
   a. A **Covered Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Covered Person's** intoxication.
8. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;

**9.** travel or flight in any aircraft except to the extent stated in the **Coverage** Section.

## SECTION VIII – GENERAL LIMITATIONS

**Limitation on Multiple Covered Losses**. If a **Covered Person** suffers more than one loss as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

**Limitation on Multiple Benefits**. If a **Covered Person** can recover benefits under more than one of the following benefits: **Accidental Death Benefit**, **Accidental Dismemberment and Covered Loss of Use Benefit, Coma Benefit**, as a result of the same **Accident,** the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

**Limitation on Multiple Hazards**. If a **Covered Person** suffers a **Covered Loss** that is covered under more than one **Hazard**, **We** will pay only one benefit, the largest benefit.

## SECTION IX - TERMINATION OF INSURANCE

**Your** Insurance**. Your** insurance terminates at the end of the month for which premium has been paid and during which any of the following occurs:

**1.** the **Policy** is terminated;

**2.** **You** cease to be eligible for insurance;

**3.** **You** fail to pay the required premium, if **You** are so required;

**4.** **You** retire.

**Conversion Privilege**

If **Your** insurance ceases for reasons other than termination of the **Policy** or nonpayment of premium, **You** are entitled to convert **Your Coverage** to an **Individual Accidental Death or Dismemberment** (**IAD)** policy or to a **Family AD&D** (**FAD)** policy if **You** selected a **Plan** covering **Your Dependents**. The new **IAD** or **FAD** policy will be on approved forms and will not include all the **Benefits** and **Additional Benefits** of the Group **Accident Policy**. **You** must make a written application for the **IAD** or **FAD** policy within sixty (60) days of the cessation of **Your** insurance under the Group **Accident Policy**. To request a Conversion Application Form, **You** must call 1-800-834-1959. **You** do not have to show proof of good health.

The issuance of the **IAD** or **FAD** policy is subject to the following conditions:

**1.** The **Principal Sum** for the **IAD** or **FAD** policy will be the lesser of **Your Principal Sum** under the Group **Accident Policy** or $100,000;

**2.** The premium for the **IAD** or **FAD** policy will be the rate on file with the proper regulatory authority, if such filing is required;

**3.** Any **IAD** or **FAD** policy issued will take effect on the termination date of **Your** insurance under the Group **Accident Policy**; and

**4.** When an **IAD** or **FAD** policy becomes effective, the relationship between **You** and **Us** will be governed by that policy, including all terms and conditions, including benefits and termination dates.

The **Conversion Privilege** will cease when **You** attain age 70.

## SECTION X - HOW TO FILE A CLAIM

**A. Notice.** **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. The notice must name the **Covered Person** who sustained the **Injury**, **You**, and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1-866-841-4771. The notice must be sent to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196-8041, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

**B. Claim Forms.** **We** will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and extent of **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss.**

**C. Proof of Covered Loss.** Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss** and the proof was provided as soon as reasonably possible.

## SECTION XI - PAYMENT OF CLAIMS

**A. Time of Payment. We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

**B. Who We Will Pay.**

**1.** **Your** Loss of Life. **Covered Losses** resulting from **Your** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to the beneficiary named by **You** for the **Policyholder's** Group Life Insurance policy. If there is no beneficiary named by **You** for the **Policyholder's** Group Life Insurance policy, or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:

**a.** **Your** legally married **Spouse** or **Domestic Partner**;

**b.** **Your Child(ren);**

**c.** **Your** parents;

**d.** **Your** brothers and sisters;

**e.** **Your** estate.

**2.** Loss of Life of **Your Covered Dependent**. **Covered Losses** for the death of **Your Covered Dependent** will be paid to **You**. If **You** pre-decease or die at the same time as **Your Covered Dependent**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.

**3.** All Other Claims. Benefits are to be paid to the **Covered Person**.

**C. Physical Examination and Autopsy. We** have the right to examine a **Covered Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

**D. Choice of Service Provider.** The **Covered Person** has the sole right to choose his or her duly licensed physician and hospital.

## SECTION XII - GENERAL POLICY CONDITIONS

**A. Beneficiaries. You** have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us.**

**B. Change or Waiver.** A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

**C. Clerical Error.** A clerical error or omission will not increase or continue **Your Coverage** which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

**D. Conformity with Statute.** Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

**E. Suit Against Us.** No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Covered Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

**F. Assignment of Interest.** A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.

In Witness Whereof, **We** have caused the **Policy** to be executed and attested, and, if required by state law, the **Policy** will not be valid unless countersigned by **Our** authorized representative.

Kristof Terryn
President
Zurich American Insurance Company

Laura J. Lazarczyk
Corporate Secretary
Zurich American Insurance Company

**NON-PARTICIPATING**

**Occidental Petroleum Corporation**
**GTU 7781876**
**Effective: January 1, 2022**

Version: January 1, 2022

# Expanded Coverage

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

| THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY. | |
|---|---|
| Policy No. 7781876 | Effective Date: January 1, 2022 |

**THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Group Accident Policy.

It is agreed that:

The following is added to **SECTION II – SCHEDULE** of the **Policy**/Certificate:

| **ADDITIONAL BENEFITS:** | **Classes Covered** |
|---|---|
| Surgical Reattachment Benefit | ALL |
| Expanded Death Benefit | ALL |

The following are added to **SECTION VI – ADDITIONAL BENEFITS** of the **Policy**/Certificate:

**SURGICAL REATTACHMENT BENEFIT**

If a **Covered Person** suffers a **Covered Injury** requiring surgical reattachment of a severed arm, leg, hand or foot, **We** will pay the benefit listed in the Surgical Reattachment Table.

To be eligible for the Surgical Reattchment Benefit:

1. the surgical reattachment must occur within 365 days after the date of the **Covered Injury**;
2. be a **Surgical Rettachment Loss**; and
3. result in **Reattachment Medical Expenses.**

Surgical Reattachment Table

For loss of:

Both Legs or Both Arms ..... 50% of **Principal Sum**

Both Hands or Both Feet ..... 50% of **Principal Sum**

One Arm and One Leg ..... 50% of **Principal Sum**

One Hand and One Foot ..... 50% of **Principal Sum**

Either Leg or Arm ..... .25% of **Principal Sum**

Either Hand or Foot ..... .25% of **Principal Sum**

Thumb and Index Finger of Same Hand ..... 10% of **Principal Sum**

Maximum – All **Surgical Reattachment Losses** – per **Covered Injury** ..... 50% of **Principal Sum**

For this benefit only, the following definitions apply:

**Hospital** means a health care facility that meets all of the following requirements:

1. holds a license as a hospital, if required;
2. operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
3. provides twenty-four (24) hour a day nursing service by registered nurses;
4. has a staff of one or more **Physicians** available at all times;
5. has facilities for diagnosis, and major medical surgical facilities; and
6. is not primarily a clinic, nursing, rest or convalescent home or similar establishment, nor is not, other than incidentally, a substance abuse center or halfway house.

**Physician** means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that **We** recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given;
3. practicing within the scope of that license referenced in 2. above.

**Reattachment Medical Expenses** means the following associated costs and/or expenses if required due to a **Surgical Reattachment Loss**:

1. medical treatment by a **Physician** or surgeon, acting within the scope of his or her license;
2. services of a licensed anesthesiologist, acting within the scope of his or her license;
3. services of a licensed nurse, acting within the scope of his or her license; and
4. **Hospital** confinement.

**Surgical Reattachment Loss** means:

1. loss of a leg by total severance at or above the knee proximal to the hip;
2. loss of an arm by total severance at or above the elbow proximal to the shoulder;
3. loss of a hand by total severance at or above the wrist proximal to the elbow;
4. loss of a foot by total severance at or above the ankle joint proximal to the knee;
5. loss of thumb and index finger by total severance at or above the knuckles proximal to the wrist.

This benefit is subject to the limitations in Section VIII General Limitations.

**EXPANDED DEATH BENEFIT**

If a **Covered Person** suffers a loss of life as a result of a **Covered Injury**, **We** will pay an Expanded Death Benefit of $5,000.

To qualify for the Expanded Death Benefit, the loss of life must occur within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VIII - General Limitations.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy**/Certificate to which it is attached.

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION**

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law if found in the *Texas Insurance Code,* Article 21.28-D.)

**BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.**

**Eligibility for Protection by the Association**

When an insurance company which is a member of the Association is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- **residents of Texas** at the time that their insurance company is impaired;
- **residents of other states,** ONLY if the following conditions are met:
    1) the policyholder has a policy with a company based in Texas;
    2) the policyholder's state of residence has a similar guaranty association; and
    3) the policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

**Limits of Protection by the Association**

**Accident, Accident and Health, or Health Insurance:**

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

**Life Insurance:**

- Net cash surrender value or net cash withdrawal value up to a total of $100,000, under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

**Individual Annuities:**

- Present value of benefits up to a total of $250,000 under one or more policies on any one life.

**Group Annuities:**

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contract holder regardless of the number of contracts.

**Aggregate Limit:**

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 unallocated group annuity limit.

**Government Plans:**

- Present value annuity benefits, in aggregate, up to a total of $250,000 including net cash surrender and net cash withdrawal values for individuals in a plan established under sections 401, 403(b), and 457 of the Internal Revenue code.

These limits are applied for each insolvent insurance company.

**THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSES OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.**

**When you are selecting an insurance company, you should not rely on coverage by the Association. For additional questions on Association protection or general information about an insurance company, please use the following contact information.**

Texas Life, Accident, and Health
Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, TX 78701
(800) 982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
(800) 252-3439 or www.tdi.texas.gov

# SANCTIONS EXCLUSION ENDORSEMENT

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY**

The following exclusion is added to the policy to which it is attached and supersedes any existing sanctions language in the policy, whether included in an Exclusion Section or otherwise:

SANCTIONS EXCLUSION

Notwithstanding any other terms under this policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any insured, beneficiary, or third party who may have any rights under this policy to the extent that such coverage, payment, service, benefit, or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

The term policy may be comprised of common policy terms and conditions, the declarations, notices, schedule, coverage parts, insuring agreement, application, enrollment form, and endorsements or riders, if any, for each coverage provided. Policy may also be referred to as contract or agreement.

We may be referred to as insurer, underwriter, we, us, and our, or as otherwise defined in the policy, and shall mean the company providing the coverage.

Insured may be referred to as policyholder, named insured, covered person, additional insured or claimant, or as otherwise defined in the policy, and shall mean the party, person or entity having defined rights under the policy.

These definitions may be found in various parts of the policy and any applicable riders or endorsements.

**ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED**

# *Privacy Notice*

## *We Take Important Steps to Protect the Personal Information We Collect About You*

***Dear Customer:*** ***rev. October 2016***

We care about your privacy. That is why we believe in your right to know what nonpublic personal information we collect about you and what we do with that information. This Privacy Notice describes the nonpublic personal information we collect about you and how we handle the information as it relates to individuals who either own or are covered by insurance we issue, or who use other financial products or services we provide.

| **Overview** | UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION |
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| **Why are you receiving this Notice?** | Financial institutions, which include the Company, choose how they share your personal nonpublic information. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your nonpublic personal information. You are receiving this Privacy Notice because our records show either that you are the owner of an insurance policy or you are (or are authorized to act on behalf of) a current insured, future beneficiary and/or claimant under a policy, product or services issued by the Company. |

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| **What types of Information do we collect?** | The types of nonpublic personal information we collect and share depend on the product or service you have with us. For example, this information can include:<br><br>• Information about you we receive from you on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, employment information, information about your income, medical information;<br>• Information about your transactions with the Company and its affiliates;<br>• Information about your claims history;<br>• Data from insurance support organizations, government agencies, insurance information sharing bureaus;<br>• Property information and similar data about you or your property; and<br>• Information we receive from a consumer reporting agency, such as a credit report.<br><br>When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice. |

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| **What do we do with the nonpublic personal information we collect?** | WE SHARE YOUR NONPUBLIC PERSONAL INFORMATION IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS OR SERVICES, AS AUTHORIZED BY LAW, OR WITH YOUR CONSENT. THIS INCLUDES SHARING, AS PERMITTED BY LAW, YOUR NONPUBLIC PERSONAL INFORMATION WITH AFFILIATED PARTIES AND NONAFFILIATED THIRD PARTIES, AS APPLICABLE, IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS. IN THE SECTION BELOW, WE LIST THE REASONS WE CAN SHARE YOUR NONPUBLIC PERSONAL INFORMATION, WHETHER WE ACTUALLY SHARE YOUR NONPUBLIC PERSONAL INFORMATION, AND WHETHER YOU CAN OPT OUT OF THIS SHARING (OR IF YOU ARE A RESIDENT OF VERMONT, WHETHER YOU HAVE THE RIGHT TO OPT IN TO ALLOWING THIS SHARING). |

| Reasons we may share your personal information | Does Company Share? | Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing? |
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| **For our everyday business purposes** – to affiliates and non-affiliates to process your transactions, administer insurance coverage, products or services, maintain your account and report to credit bureaus | Yes | No |
| **For our marketing purposes or for joint marketing with other financial companies** | No | We don't share |
| **For our affiliates' everyday business purposes** – transaction and experience information | Yes | No |
| **For our affiliates' everyday business purposes** – creditworthiness | No | No |
| **For our affiliates to market to you** | Yes | No |
| **For non-affiliates to market to you** | No | We don't share |

| **Collecting and safeguarding information** | |
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| **How often does the Company notify me about their practices?** | We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision. |
| **Why and how does the Company collect my nonpublic personal information?** | We collect nonpublic personal information when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. We collect personal information from:<br>• Applications, forms and telephone, web site or written contact with you. This information can include social security number, driver's license number and income.<br>• Your transaction(s) with us, our affiliates and other non-affiliated third parties. Transactional information includes such things as your insurance coverage, premiums, claims and payment history. Non-affiliated third parties may include appraisers, investigators, insurance companies, etc.<br>• Information from physicians, hospitals and other medical providers. We collect this information only in connection with the issuance of individual or group insurance policies on your life or health, and with the processing and adjustment of claims under that insurance.<br>Information in a report prepared by an insurance support organization may be retained by that organization and provided to others. |
| **What nonpublic personal information does the Company disclose?** | We may provide to an affiliated or non-affiliated party the same nonpublic personal information listed above in the section entitled, "What information do we collect?". |

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| **How does the Company safeguard my nonpublic personal information?** | Employees who have access to your nonpublic personal information are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards. |

**FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:**

**You have the following individual rights under state law:**

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information you must submit a written request reasonably describing the information you seek, and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information. If you request medical records, we may elect to supply that information to you through your designated medical professional. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once in writing, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You must make your request in writing and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.

**FOR RESIDENTS OF MASSACHUSETTS ONLY:** You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

| **Key words and phrases** | TERMS YOU SHOULD KNOW |
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| **Definitions** | |
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| **Everyday business purposes** | The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as:<br>• Processing transactions, mailing and auditing services<br>• Administering insurance coverage, product, services or claims<br>• Providing information to credit bureaus<br>• Protecting against fraud<br>• Responding to court/governmental orders or subpoenas and legal investigations<br>• Responding to insurance regulatory authorities |
| **Affiliates** | Financial or nonfinancial companies related by common ownership or control.<br>• *Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.* |

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| **Non-affiliates** | Financial or nonfinancial companies not related by common ownership or control. We do not rent or sell your nonpublic personal information. However, we may share your information with companies that we hire to perform business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we disclose information to others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the business services.<br>• *Company does not share information with non-affiliates to market to you*. |
| **Joint marketing** | A formal agreement between non-affiliated financial companies that together market financial products or services to you.<br>• *Company does not jointly market.* |

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| **Changes to this Privacy Notice; contact us** | We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes.<br><br>If you have any questions about your contract with us, you should contact your agent.<br><br>If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. |

This Privacy Notice is sent on behalf of the following affiliated companies:

*American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (hereinafter individually and collectively referred to as "Company")*.


The full Summary Plan Description includes this Benefit Program SPD and the wrap-around summary plan description (“Wrap SPD). The Wrap-SPD may be accessed here. Alternatively, to request a hardcopy or an electronic copy please contact the OxyLink Employee Service Center (OxyLink) by email or call 1-800-699-6903 (inside US) and 1-918-610-1990 (outside US).

Posted April 2022