SCHEDULE

****REVISED****

POLICY NO.: SR2014PA-P-120176

POLICYHOLDER INFORMATION:

Great Crate Racing, LLC dba RUSH Racing Series
4368 US 422
Pulaski, PA 16143

Effective Date: January 1, 2022 **Expiration Date:** January 1, 2023

ELIGIBILITY:

Class 1: All Participants in Policyholder scheduled and sanctioned events/activities other than non-caged karting events/activities.
Class 2: All Participants in Policyholder scheduled and sanctioned non-caged karting events/activities.

Participants means drivers/riders, mechanics, crew persons and officials of the race bearing a duly and official pit pass in a restricted area. The participant must be a current dues paying member and on file with Reel Media Insurance Services, LLC at the time of the incident.

COVERED ACTIVITIES:

Policyholder sponsored or supervised events/activities at a Policyholder sanctioned location that:

1. are in a Restricted Area; and
2. have been reported to Us prior to occurring; and
3. that appear on the Activity Report on file with Us.

"Restricted area" is an area requiring special authorization, credentials or permission to enter, or any area which the admission of the general public is restricted or prohibited.

SCOPE OF COVERAGE:

Class	**Insured Risk**	**Benefits**
ALL	Activity Coverage (IRACT066)	AD Specific Loss & Paralysis (ADSL4PLEG001-PA) AME (AMEMTR001)

BENEFITS:

Accidental Death & Specific Loss Aggregate Limit of Liability (TBAGGLIM002) $500,000.00

Accidental Death & Specific Loss (ADSL4PLEG001-PA)

Class 1 Principal Sum Amount	$10,000.00 per Injury
Class 2 Principal Sum Amount	$10,000.00 per Injury
Principal Sum Amount	$10,000.00
Loss Period – Specific Loss only	Loss within 365 Days of Injury

Paralysis Benefit

Uniplegia	25% of Principal Sum
Hemiplegia	50% of Principal Sum
Paraplegia	75% of Principal Sum
Quadriplegia	100% of Principal Sum

Medical Expense for Accident (AMEMTR001) - Full Excess (TBFE004/TBFIFTY002*)

Class 1 Maximum Benefit Amount	$100,000.00 per Injury
Class 2 Maximum Benefit Amount	$25,000.00 per Injury
Deductible (Reducing)	$10,000.00 per Injury
Loss Period	Initial treatment received within 90 days of Injury
Benefit Period	Benefits payable for 52 weeks from accident date

* If an Insured fails to follow the terms and conditions of the Insured's primary coverage, We will reduce eligible Medical Expenses to 50% of the amount We would otherwise pay.

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

Guaranty Association Notice	M20234_1220

PREMIUM:

Member Coverage - automobile	$17.00 per Member
Member Coverage – caged kart	$34.00 per Member
Member Coverage – uncaged kart	$40.00 per Member

This plan has a non-refundable minimum premium of $1,000.00 per policy year, which is fully earned upon issuance of the policy.

122821:scs
Corrected eligibility language; 011022:scs

Mutual of Omaha

3300 Mutual of Omaha Plaza
Omaha, NE 68175

This policy is issued to Great Crate Racing, LLC dba RUSH Racing Series ("the Policyholder").

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

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

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

This policy is nonparticipating. No dividends will be paid.

EFFECTIVE DATE AND POLICY TERM

This policy takes effect on January 1, 2022 (the Policy Effective Date) at the Policyholder's main office. It expires on January 1, 2023.

POLICY NUMBER: SR2014PA-P-120176

THIS IS A BLANKET LIMITED ACCIDENT POLICY.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

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

James T. Blackledge

Chief Executive Officer

Jay A. Vanbat

Corporate Secretary

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INSURED RISKS

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

ACTIVITY COVERAGE (IRACT066)

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

- attending or participating in a Sponsored or Supervised Activity.

ELIGIBILITY FOR BENEFITS

ELIGIBILITY

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

WHEN INSURANCE BEGINS

Insurance for an Insured begins on the later of:

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

CHANGE IN COVERAGE

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

WHEN INSURANCE ENDS

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

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

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

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFIT (ADSL4PLEG001-PA)

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

The Principal Sum is shown in the Schedule.

TABLE OF BENEFITS FOR ACCIDENTAL DEATH AND SPECIFIC LOSS

Loss	*Benefit Amount*
Loss of Life	100% of Principal Sum
Loss of Both Hands	100% of Principal Sum
Loss of Both Feet	100% of Principal Sum
Loss of Entire Sight of Both Eyes	100% of Principal Sum
Loss of One Hand and One Foot	100% of Principal Sum
Loss of One Hand and Entire Sight of One Eye	100% of Principal Sum
Loss of One Foot and Entire Sight of One Eye	100% of Principal Sum
Loss of Speech and Hearing	100% of Principal Sum
Loss of Entire Sight of One Eye	50% of Principal Sum
Loss of Speech or Hearing	50% of Principal Sum
Loss of One Hand or One Foot	50% of Principal Sum
Loss of Thumb and Index Finger	25% of Principal Sum
Quadriplegia (complete loss of function) of Four Limbs	100% of Principal Sum
Paraplegia (complete loss of function) of Both Lower Limbs	75% of Principal Sum
Hemiplegia (complete loss of function of one side of the body with involvement of the arm and leg)	50% of Principal Sum
Uniplegia (complete loss of function of one upper limb or one lower limb)	25% of Principal Sum

MEDICAL EXPENSE FOR ACCIDENT BENEFIT (AMEMTR001)

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

1. Hospital room and board charges, up to the average semi-private daily room rate, for each day in the Hospital;
2. Intensive Care Unit charges are payable in lieu of payment for Hospital room and board charges for each day the Insured is confined in an intensive care unit;
3. Hospital miscellaneous charges during a hospital confinement. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take-home items, or other convenience items;
4. outpatient charges by a Hospital for:
    a. emergency room treatment. Treatment must be received within 72 hours of the Accident;
    b. emergency room physician; or
    c. use of surgical facilities;
5. surgical charges for the primary performance of a surgical procedure by a Physician; subject to the following:
    a. if bilateral or multiple surgical procedures are performed by one Physician, We will pay the Medical Expenses for the primary procedure;
    b. for each procedure that is not the primary procedure performed through the same incision as the primary procedure, we will pay 50% of the amount otherwise payable if the additional procedure were the primary procedure;

c. if multiple surgical procedures are performed during the same operating session, reimbursement shall be based upon, 100% of Allowable Expense for the primary procedure, 50% of Allowable Expense for the secondary procedure and 25% of Allowable Expense for the third and subsequent procedures;
d. any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental and no benefits will be provided for such procedure;
e. if multiple unrelated surgical procedures are performed by two or more Physicians on separate operative fields, benefits will be based on the Medical Expenses for each Physician's primary procedure; and
f. if two or more Physicians perform a procedure that is normally performed by one Physician, We will only pay the Medical Expenses for the primary Physician;

6. charges for a second surgical opinion or consultation by a Physician;
7. surgical charges for assistant surgeon duties will be reimbursed at 25% of the allowable for surgery codes that have been assigned an assistant surgery indicator by the Centers for Medicare & Medicaid Services;
8. charges for anesthesia and its administration for surgery;
9. Physician's charges for other than pre- or post-operative care for in-Hospital visits or office visits;
10. charges for, including Physician's charges for reading or interpreting the results of, Laboratory Tests and diagnostic imaging including X-Ray, MRI, or CAT Scan;
11. charges for nursing services, other than routine Hospital care, by or under the supervision of a Nurse;
12. treatment of the spine by manual or mechanical means;
13. charges for Durable Medical Equipment;
14. charges for physiotherapy which includes:
    a. adjustment;
    b. diathermy;
    c. heat treatment;
    d. manipulation;
    e. microtherm;
    f. ultrasonic;
15. Ambulance Service (Surface) or and Ambulance Service (Air);
16. Orthopedic Appliances and prosthetics, not including replacements;
17. Prescription Drugs;
18. dental expense for sound natural teeth;
19. extended dental expense for the replacement of caps, crowns, dentures, braces or other orthodontic appliances when damaged due to Accident;
20. other Medical Expenses as noted in the Schedule.

EXCLUSIONS (EXMTR002)

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

1. intentionally self-inflicted injury, suicide while sane or insane;
2. voluntary self-administration of any drug or chemical substance not prescribed by or not taken according to the directions of the Insured's Physician;
3. treatment for alcoholism or drug addiction;
4. Injury caused by, attributable to, or resulting from the Insured's Intoxication;
5. Injury caused by, attributable to, or resulting from the Insured's use of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
6. operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
7. operating a motor vehicle while having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred;
8. commitment of or an attempt to commit a felony, or engagement in an illegal activity;
9. participation in a riot or insurrection;
10. any Injury that results from fighting, brawling, assault or battery;
11. an act of declared or undeclared war;
12. active duty service in any Armed Forces;
13. operating, learning to operate, or serving as a pilot or crew member of any aircraft;
14. sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning;
15. dental treatment or dental X-rays, except as otherwise provided, and only when Injury occurs to sound natural teeth;
16. orthodontic braces or appliances;
17. any loss for which benefits are paid under state or federal worker's compensation, employers' liability, or occupational disease law;
18. treatment in any Veterans Administration or federal Hospital, unless there is a legal obligation to pay;
19. charges which the Insured would not have to pay if the Insured did not have insurance;
20. a charge which is in excess of the Allowable Expense;
21. cosmetic surgery, except reconstructive surgery due to a covered Injury;
22. elective treatment or surgery that is not prescribed by a Physician and is not Medically Necessary, health treatment, or examination where no Injury is involved;
23. preventive medicines or, serums or, vaccines;
24. routine medical care and normal health checkups;
25. rest cures or Custodial Care;
26. blood or blood plasma, except for charges by a Hospital for the processing or administration of blood;
27. mental and nervous disorders;
28. Pre-existing Conditions;
29. human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC);
30. infectious disease;
31. any Heart or Circulatory Malfunction;
32. services or treatment rendered by a Physician, Nurse or any other person who is:
    a. employed or retained by the Policyholder/Sponsoring Organization; or
    b. the Insured or an Immediate Family Member;
33. services or treatment incurred to the extent that they are paid or payable under any Other Insurance Plan;
34. services or treatment incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. This exclusion does not apply in any state where it is prohibited;
35. eyeglasses, contact lenses, hearing aids, or related examinations or prescriptions;
36. treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;
37. treatment of a hernia.

38. participation in professional racing;
39. injuries associated with activities or travel outside the United States.

TERMS OF BENEFIT PAYMENTS

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

FULL EXCESS MEDICAL EXPENSE (TBFE004 / TBFIFTY002)

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

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

The Maximum Benefit Amount payable and sub-limits under this policy are shown in the Schedule.

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

AGGREGATE LIMIT OF LIABILITY (TBAGGLIM002)

The Aggregate Limit of Liability is shown in the Schedule. We will not be liable for any amount over this limit for any one Accident. If the total amount of benefits to be paid to two or more Insureds is more than the Aggregate Limit of Liability, the benefit We will pay for each Insured's loss will be a proportionate share of the Aggregate Limit of Liability.

NON-DUPLICATION OF BENEFITS

This provision applies if an Insured:

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

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

CLAIM PROVISIONS

NOTICE OF CLAIM

We must receive written notice within 60 days after a loss occurs or begins, or as soon as reasonably possible. Notice can be given at Our home office or to Our authorized representative. Notice should include:

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

CLAIM FORMS

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

PROOF OF LOSS

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

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

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

Physical Examination and Autopsy

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

PAYMENT OF CLAIMS

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

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

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

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

- to the Insured's surviving Spouse; if none, then
- in equal shares to the Insured's surviving children; if none, then
- in equal shares to the Insured's surviving parents; if none, then
- in equal shares to the Insured's surviving brothers and sisters; if none, then
- to the Insured's estate.

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

Assignment of Benefits

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

OPPORTUNITY TO REQUEST AN APPEAL

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

The request for an appeal should include:

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

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

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

AUTHORITY TO INTERPRET POLICY

By purchasing this policy, the Policyholder/Sponsoring Organization grants Us the discretion and the final authority to construe and interpret this policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any policy benefits within the terms of this policy as We interpret it. We will pay benefits under this policy only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder/Sponsoring Organization, an Insured, or any other third party. Our interpretation of this policy as to the amount of benefits and eligibility will be binding and conclusive on all persons.

The Policyholder/Sponsoring Organization further grants Us the authority to delegate to third parties, including, without limitation, any third party administrator with whom We have contracted to provide claims administration and other administrative services, the discretionary authority granted in this policy. The Policyholder/Sponsoring Organization expressly grants such third party the full discretionary authority granted to Us under this policy.

PREMIUM PROVISIONS

REPORTING REQUIREMENTS

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

GRACE PERIOD

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

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

If We have not been notified otherwise and the premium has not been paid, this policy will end when the grace period ends.

CHANGES IN RATES

We have the right to change the premium rates:

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

New rates based on coverage or eligibility changes will take effect on the effective date of those changes. Otherwise, we will give 31 days written notice when we change the rates. Notice will be sent to the Policyholder/Sponsoring Organization's most recent address in Our records.

REINSTATEMENT AFTER TERMINATION

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

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

GENERAL PROVISIONS

INSURANCE CONTRACT

The insurance contract consists of:

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

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

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

WORKERS COMPENSATION INSURANCE

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

POLICYHOLDER/SPONSORING ORGANIZATION RECORDS

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

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

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

REIMBURSEMENT/SUBROGATION

Applicability

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

Obligations of Insured

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

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

If a third party pays the Insured directly based on an agreement, the Insured must reimburse Us the amount of any payments We previously made to the Insured (or for which We may have future responsibility) with respect to Injury covered by this

policy. The Insured must hold any recovery or payment (including amounts paid for future medical expenses) and any right of recovery against the third party in trust for Us.

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

Our Rights

We may:

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

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

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

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

Priority; Other Legal Doctrines

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

POLICY TERMINATION

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

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

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

CONFORMITY WITH STATE STATUTES

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

LEGAL ACTIONS

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

CERTIFICATES OF INSURANCE

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

DEFINITIONS

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

Accident means an unexpected and unintended event which:

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

Ambulance Service (Air) means the service provided:

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

Ambulance Service (Surface) means the service provided:

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

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

Ambulatory Surgical Center means a surgical or medical center which:

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

Approved Racing Event means the period of time during which actual speed contests, performances, or testing of land motor vehicles is conducted and for which a valid premium has been paid in advance.

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

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

Custodial Care means services or treatment which, regardless of where provided:

- could be rendered safely by a person without medical skills; and
- provides a routine level of maintenance care designed mainly to help the patient with daily living activities, including (but not limited to):
    - personal care such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomy; exercising; dressing; enema and using the toilet;
    - homemaking such as preparing meals or special diets;
    - moving the patient;
    - acting as companion or sitter;
    - supervising medication which can usually be self-administered;

- oral hygiene; and
- ordinary skin and nail care.

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

Durable Medical Equipment means equipment that is Medically Necessary, appropriate for the medical care of the Insured, and ordered by a Physician for the specific use of the Insured. It is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose and generally is not useful to an individual in the absence of an Injury.

Heart or Circulatory Malfunction means an acute onset of a cardiovascular or circulatory accident, stroke or other similar traumatic event affecting the heart or circulatory system:

- which is first diagnosed and treated while the Insured's coverage under this policy is in force;
- which occurs as a result of Injury to the Insured while participating in a Sponsored or Supervised Activity; and
- which does not result from a Pre-Existing Condition.

Home Health Care means nursing care and treatment, to an Insured in his home, which is part of an overall extended treatment plan and; a) is required for progressive and positive improvement of the Insured's medical condition, or b) is necessary to provide care and treatment that cannot be self-administered for a Totally Disabled Insured.

To qualify for Home Health Care:

- the plan must be established and approved in writing by the attending Physician, including certification in writing by the attending Physician that confinement in a Hospital or Extended Care Facility would be required in the absence of Home Health Care; and
- nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency; and
- Home Health Care services must commence within seven (7) days of discharge from a Hospital or Extended Care Facility or Rehabilitation Facility and be preceded by a Hospital or Extended Care Facility or Rehabilitation Facility confinement of five (5) days or more.

Home physical, speech, and occupational therapies will be covered when initiated in conjunction with discharge from or placement through a Rehabilitation Facility and approved by the attending Physician.

No benefits will be paid for Home Health Care services which are provided by an Immediate Family Member of the Insured or by an individual who resides with the Insured, unless specifically agreed to by Us. Home Health Care does not include Custodial Care Expense.

Hospital means an institution which:

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

Hospital does not include:

- a clinic or facility for:
  - convalescent, custodial, educational or nursing care;
  - the aged, drug addicts or alcoholics;
  - rehabilitation; or
- a military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
  - the services are rendered on an emergency basis; and

- the individual has a legal liability to pay for the services given in the absence of insurance.

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

Injury means bodily harm which:
- requires treatment by a Physician;
- results in loss due to an Accident, independent of Sickness and all other causes; and
- occurs within the Scope of Coverage.

Bodily harm does not include a Pre-Existing Condition.

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

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

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

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

Loss of a Foot means Severance above the ankle.

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

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

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

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

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

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

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

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

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

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

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

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

Orthopedic Appliances means braces and appliances that:

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

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

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

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

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

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

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

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

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

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

Prescription Drugs means drugs which:

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

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

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

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

Skilled Nursing Facility means a place which is licensed by the state as a skilled nursing home.

Sponsored or Supervised Activity means a Policyholder/Sponsoring Organization authorized function:

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

Sponsoring Organization means a legal entity to whom this policy is issued, that is affiliated with the Policyholder, or that elects coverage under this policy.

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

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

THIS IS A BLANKET LIMITED ACCIDENT POLICY.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

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

Mutual of Omaha Insurance Company

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

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:

- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):

- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual annuities

- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;

- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
- If the person is provided coverage by the guaranty association of another state
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.