OCCUPATIONAL ACCIDENT

CERTIFICATE OF INSURANCE

FOR PARTICIPATING CONTRACTORS OF EARL L. HENDERSON TRUCKING COMPANY, INC.

AS A PARTICIPATING ORGANIZATION IN THE

TRUCKING INDUSTRY GROUP INSURANCE TRUST

IMPORTANT NOTICE

THIS INSURANCE IS NOT WORKERS' COMPENSATION INSURANCE.
IT IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION INSURANCE.

THIS INSURANCE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.

IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.

Limited Benefit, Please Read Carefully

NOTE: This Certificate of Insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

Atlantic Specialty Insurance Company
605 North Highway 169
Plymouth, MN 55441

POLICYHOLDER:	**Trucking Industry Group Insurance Trust** **Trustee: SunTrust Bank**
PARTICIPATING ORGANIZATION:	**Earl L. Henderson Trucking Company, Inc.**
POLICY NUMBER:	**216-002-069**
COVERED SUBSIDIARIES AND/OR AFFILIATED COMPANIES:	**Tennant Truck Lines, Inc.** **Trekker Logistics, LLC**

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.

The Policy upon which this Certificate is based, is governed by the laws of the District of Columbia.

OCCUPATIONAL ACCIDENT
CERTIFICATE OF INSURANCE

Table of Contents

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

ELIGIBILITY

You are eligible to become an **Insured Person** provided **You** are at least eighteen (18) years of age, have completed enrollment material on file with the **Participating Organization**, and **You** are either:

Class I:

An **Owner-Operator** who is enrolled for coverage under the **Policy**. For purposes of the **Policy**, an **Owner-Operator** must lease to the **Participating Organization** as indicated on page 2 of this **Certificate**, and must:

1. have a valid and current Commercial Driver's License or the required license for the vehicle he or she is assigned to operate;
2. own or lease a power unit;
3. be responsible for the maintenance of the power unit;
4. be responsible for the operating costs of the power unit, including but not limited to fuel, repairs, supplies and other expenses associated with the operation of the power unit;
5. be responsible for maintaining physical damage insurance on the power unit;
6. be responsible for hiring and supervising personnel who operate the power unit;
7. be compensated on a basis other than time expended in the performance of work;
8. be responsible for determining the route and hours for an assignment;
9. have the right to select the load;
10. have a written contract or assignment from the person who has engaged his or her services which provides that he or she is an Independent Contractor;
11. be classified as an Independent Contractor by the person who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;
12. not be an employee of the **Participating Organization**; and
13. receive a 1099 form for federal income tax reporting purposes, not a W-2.

Class II:

A **Contract Driver** who is enrolled for coverage under the **Policy**. For purposes of the **Policy**, a **Contract Driver** must:

1. have a valid and current Commercial Driver's License or the required license for the vehicle he or she is assigned to operate;
2. be authorized by an **Owner-Operator** to operate a power unit owned or leased by an **Owner-Operator**. (The **Contract Driver** must neither own nor lease the power unit.);
3. be compensated on a basis other than time expended in the performance of work;
4. be responsible for determining the route and hours for an assignment;
5. operate the power unit of the **Owner-Operator** who has engaged his or her services as an Independent Contractor. (Operating the unit must be the principal duty of the **Contract Driver**.)
6. be classified as an Independent Contractor by the **Owner-Operator** who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;
7. receive a 1099 form for federal income tax reporting purposes, not a W-2;
8. not be an employee of the **Participating Organization**; and
9. not be an employee of the **Owner-Operator**.

NOTE: A **Contract Driver** who operates a power unit that is not owned or leased by an **Owner-Operator**, as defined in the **Policy**, is **not** eligible for coverage under the **Policy**.

You cannot be covered by any other **Occupational Accident Policy** issued by **Us**.

If **You** pay premium but are not eligible for coverage or do not qualify for benefits under the **Policy**, **We** will refund any premium paid in error.

YOUR COVERAGE EFFECTIVE DATE

Class I-Owner-Operator: If **You** are an **Owner-Operator**, **Your** coverage under the **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date **You** become a member of an eligible Class as described above;
3. the date **Your** completed enrollment form is received by the **Participating Organization** or an authorized person designated by the **Participating Organization**.

Class II-Contract Driver: If **You** are a **Contract Driver**, **Your** coverage under the **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date **You** become a member of an eligible Class as described above;
3. the date **Your** completed enrollment form is received by the **Participating Organization** or an authorized person designated by the **Participating Organization**.

Your coverage will not become effective until the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of 1, 2 or 3 above. If premium is not paid when due, coverage will not be in effect.

YOUR COVERAGE TERMINATION DATE

Class I-Owner-Operator: If **You** are an **Owner-Operator**, **Your** coverage under the **Policy** ends on the earliest of:

1. the date the **Policy** is terminated;
2. the premium due date, if premiums are not paid when due, subject to the Grace Period (except for the first premium which is not subject to the Grace Period);
3. the date **You** request, in writing, that **Your** coverage be terminated; or
4. the date **You** cease to be a member of an eligible Class as described above.

Class II-Contract Driver: If **You** are a **Contract Driver**, **Your** coverage under the **Policy** ends on the earliest of:

1. the date the **Policy** is terminated;
2. the premium due date, if premiums are not paid when due, subject to the Grace Period (except for the first premium which is not subject to the Grace Period);
3. the date **You** request, in writing, that **Your** coverage be terminated;
4. the date **You** cease to be a member of an eligible Class as described above; or
5. the date the **Owner-Operator**, with respect to whom **You** are under contract, ceases to be a member of an eligible Class as described above.

A change in **Your** coverage under the **Policy**, due to a change in **Your** eligible Class or benefit selection, becomes effective on the later of: (1) the date the change in **Your** eligible Class or benefit selection occurs; or (2) if the change requires a change in premium, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Covered Accidents** that occur after the change becomes effective.

Subject to the terms, conditions, exclusions and limitations of the **Policy**, termination of coverage will not affect a claim for a **Covered Loss** that occurs either before or after such termination, if that **Covered Loss** results from an **Accident** that occurred while **Your** coverage was in force under the **Policy**.

SECTION II – SCHEDULE OF BENEFITS

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
- **Principal Sum** * $50,000
- **Accident Commencement Period** ..... 365 days

Survivor's Benefit:
- **Principal Sum *** ..... up to $200,000
- Monthly Benefit Percentage 1.0%
- Monthly Benefit Amount $2,000

Accidental Dismemberment Benefit:
- % of **Principal Sum *** ..... up to $250,000
- **Accident Commencement Period** ..... 365 days

Paralysis Benefit:
- % of **Principal Sum *** ..... up to $250,000
- **Accident Commencement Period** ..... 365 days

Temporary Total Disability Benefit:
- **Disability Commencement Period** ..... 90 days
- **Waiting Period** ..... 7 days
- Benefit Percentage ..... 70% of **AWE**
- **Minimum Weekly Benefit Amount** $125
- **Maximum Weekly Benefit Amount** $500
- **Maximum Benefit Period** ** ..... 104 weeks
- **Maximum Benefit Period** for Hernia ..... 10 weeks
- **Maximum Benefit Period** for Hemorrhoids ..... 10 weeks
- **Maximum Benefit Period** for **Occupational Cumulative Trauma** and/or **Repetitive Conditions** ..... 10 weeks

Continuous Total Disability Benefit: ***
- **Waiting Period** ..... **Maximum Benefit Period** for **Temporary Total Disability**
- Benefit Percentage ..... 70% of **AWE**
- **Minimum Weekly Benefit Amount** $50
- **Maximum Weekly Benefit Amount** $500
- **Maximum Benefit Amount** ..... ….$200,000
- **Maximum Benefit Period** ..... to age 70

Accident Medical Expense Benefit:
- **Medical Commencement Period** ..... 90 days
- **Deductible Amount** $0
- **Maximum Benefit Period** ..... 104 weeks
- Dental Maximum ..... $3,600 per **Accident**
- **Maximum Benefit Amount** per **Accident** $1,000,000
- Lifetime **Maximum Benefit** $1,000,000

Limits on **Accident Medical Expense** Benefits:

Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $1,000 per **Injury**

Ambulance ..... one round trip to and from a **Hospital** ….but not more than $1,000 for any one **Accident**

Air Ambulance ..... one round trip to and from a **Hospital** ….but not more than $7,000 for any one **Accident**

Hernia, Hemorrhoid, **Occupational Cumulative Trauma** and/or **Repetitive Conditions** Coverage ..... combined lifetime **Maximum Benefit** of $50,000

Mental and Nervous – Outpatient.....$25.00 per visit
….maximum 20 visits for any one **Accident**

Mental and Nervous – Inpatient..... maximum 20 days
….maximum $1,000 for any one **Accident**

OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- **Combined Single Limit** $1,000,000
- **Aggregate Limit of Liability** $2,000,000
  (applicable to all **Covered Losses** with respect to any one **Occupational Accident**)

***** The **Accidental** Dismemberment Benefit and the Paralysis Benefit will be paid as a Monthly Benefit at 1% of the applicable **Principal Sum**. The payment of this Monthly Benefit will cease upon the earliest of the following: (1) the date the total of the applicable **Principal Sum** has been paid; or (2) the date **You** die. The most **We** will pay for this benefit, as well as the **Accidental** Death Benefit, in total, is **Your** maximum **Principal Sum**, if **You** can recover benefits under more than one of the benefits as a result of the same **Accident**.

At age 65, **Your Principal Sum** will be based on the following schedule:

For Death and Survivor Benefits, Age at Date of **Covered Loss**	
For Dismemberment and Paralysis Benefits, Age at Date of Benefit Payment	% of **Principal Sum**
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

** If **You** sustain a **Covered Injury** at or after age 70, the **Maximum Benefit Period** will be one (1) year.

***If **You** sustain a **Covered Injury** after **Your** normal Social Security retirement age, as determined by federal law, **You** cannot qualify for **Continuous Total Disability**.

NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
Principal Sum * $10,000
Accident Commencement Period..... 365 days

Accidental Dismemberment Benefit:
% of **Principal Sum ***..... up to $10,000
Accident Commencement Period..... 365 days

Accident Medical Expense Benefit:
Medical Commencement Period..... 90 days
Deductible Amount $0
Maximum Benefit Period..... 52 weeks
Dental Maximum ..... $1,000 per **Accident**
Maximum Benefit Amount per **Accident**..... $5,000
Lifetime **Maximum Benefit** $10,000

Limits on **Accident Medical Expense** Benefits:

Physical Therapy, Occupational Therapy, Work Hardening Therapy..... $3,600 per **Injury**

Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $1,000 per **Injury**

Ambulance .....one round trip to and from a **Hospital**
but not more than $1,000 for any one **Accident**

Air Ambulance..... one round trip to and from a **Hospital**
but not more than $7,000 for any one **Accident**

Mental and Nervous – Outpatient.....$25.00 per visit
maximum 20 visits for any one **Accident**

Mental and Nervous – Inpatient..... maximum 20 days
maximum $1,000 for any one **Accident**

NON-OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- **Combined Single Limit**..... $10,000
- **Aggregate Limit of Liability**..... $20,000
  (applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident)**

***** The **Accidental** Dismemberment Benefit will be paid as a Monthly Benefit at 1% of the applicable **Principal Sum**. The payment of this Monthly Benefit will cease upon the earliest of the following: (1) the date the total of the applicable **Principal Sum** has been paid; or (2) the date the **You** die. The most **We** will pay for this benefit, as well as the **Accidental** Death Benefit, in total, is **Your** maximum **Principal Sum**, if **You** can recover benefits under more than one of the benefits as a result of the same **Accident**.

At age 65, **Your Principal Sum** will be based on the following schedule:

For Death Benefit, Age at Date of **Covered Loss**	
For Dismemberment Benefit, Age at Date of Benefit Payment	% of **Principal Sum**
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

SECTION III – PREMIUM

Premium Amount:

Class I: as stated in the Policy
Class II: as stated in the Policy
Class III: as stated in the Policy

If **You** enroll on or prior to the 15th of the month, **You** will pay an amount equal to the full monthly premium. No premium will be payable for the last full or partial month of coverage.

If **You** enroll after the 15th of the month, **You** will pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, **You** will pay an amount equal to the monthly premium.

Exception: If **You** enroll on or after the 15th of one month and then terminate coverage prior to the 15th of the following month, **You** will owe one full month of premium.

Grace Period:

A Grace Period of thirty-one (31) days will be provided for the payment of any premium due after the first premium. **Your** coverage will not be terminated for nonpayment of premium during the Grace Period if **You** pay the premiums due by the last day of the Grace Period. **Your** coverage will terminate on the premium due date if all premiums due are not paid by the last day of the Grace Period.

No Grace Period will be provided if **We** receive notice to terminate **Your** coverage prior to a premium due date.

Waiver of Premium:

Subject to the **Policy** remaining in force, all premiums due under the **Policy** with respect to **You** receiving either a **Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit under the **Policy** will be waived. Premiums will be waived from the first premium due date on or after the date the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit begins. Premium payments must be resumed on the premium due date next following the date **Your Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit ceases. If premium payments are not resumed on that date, **Your** coverage under the **Policy** will end on that date. **You** are responsible for reporting Waiver of Premium to the **Participating Organization**, or an authorized person designated by the **Participating Organization**, or **Us**.

SECTION IV – BENEFITS

ACCIDENTAL DEATH BENEFIT

If a **Covered Injury** to **You** results in death within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the **Principal Sum** shown in the **Schedule**. The **Accident Commencement Period** starts on the date of the **Accident** that caused such **Injury**. If **You** suffer an **Accidental** Death such that an **Accidental** Death Benefit is payable under the **Policy**, **We** will pay **Your** beneficiary in accordance with the Payment of Claims provision.

Survivor's Benefit (does not apply to a **Non-Occupational Accident**)

The Monthly Benefit Amount will be as described in the **Schedule**. The Monthly Benefit Amount will be paid to **Your** surviving **Spouse** up to the **Principal Sum** shown in the **Schedule**.

If **You** are not survived by a **Spouse**, or if **Your Spouse** dies or remarries, **We** will pay or continue to pay the Survivor's Benefit to **Your** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. The payment of the monthly Survivor's Benefit will end on the earliest of the following dates:

1. the date **Your Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date **Your** last **Dependent Child** dies or is no longer eligible as defined in the GENERAL DEFINITIONS Section of the **Policy**; or
3. the date the **Principal Sum** has been paid.

If **You** are not survived by a **Spouse** or any **Dependent Child(ren)**, **We** will pay only the **Accidental** Death Benefit in accordance with the Payment of Claims provision of the **Policy**. **We** will not pay a Survivor's Benefit.

Exposure and Disappearance

If **You** are 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 **Your** body has not been found within 365 days after the disappearance, stranding, sinking or wrecking of a power unit in which **You** were an occupant, then it will be presumed, subject to all other terms and provisions of the **Policy**, that **You** have suffered **Accidental** Death within the meaning of the **Policy**. If **You** are subsequently found alive and identified, **We** have the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to **You** results in any one of the **Covered Losses** specified below, within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below.

For **Covered Loss** of:	Percentage of the **Principal Sum**
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%

One Hand or One Foot 50%
Sight of One Eye 50%
Thumb and Index Finger of Same Hand 25%

For purposes of the **Accidental** Dismemberment Benefit, **Loss** will mean:

Loss of a hand or foot means complete severance through or above the wrist or ankle joint. **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye. **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If **You** sustain more than one **Loss** as a result of the same **Covered Accident**, only one amount, the largest, will be paid.

PARALYSIS BENEFIT (does not apply to a **Non-Occupational Accident**)

If a **Covered Injury** to **You** results in any Type of Paralysis specified below, within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below.

Type of Paralysis:	Percentage of the **Principal Sum**
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Uniplegia	25%

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**. **Paraplegia** means the complete and irreversible paralysis of both lower **Limbs**. **Hemiplegia** means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body. **Uniplegia** means the complete and irreversible paralysis of one **Limb**. For purposes of this benefit **Limb** means entire arm or entire leg.

If **You** sustain more than one Type of Paralysis as a result of the same **Covered Accident**, only the largest single amount will be considered a **Covered Loss**.

TEMPORARY TOTAL DISABILITY (TTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

TTD Benefit Qualifications.

If a **Covered Injury** to **You** results in **Temporary Total Disability** within the **Disability Commencement Period** shown in the **Schedule**, **We** will pay the **Temporary Total Disability** Benefit specified below, subject to satisfaction of any applicable **Waiting Period** shown in the **Schedule**. The **Disability Commencement Period** starts on the date of the **Accident** that caused such **Injury**. After the **Waiting Period** has been satisfied, the **Temporary Total Disability** Benefit will be payable from the day the **Waiting Period** was satisfied.

TTD Benefit Amount.

The **Temporary Total Disability** Benefit with respect to each week of **Your Temporary Total Disability** during a **Single Period of Total Disability** is equal to the lesser of:

1. the Benefit Percentage (as shown in the **Schedule**) of **Your Average Weekly Earnings (AWE)**; or
2. the **Maximum Weekly Benefit Amount** shown in the **Schedule**.

In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Temporary Total Disability** Benefit with respect to less than a full **Benefit Week** of **Temporary Total Disability** equals 1/7th of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

TTD Benefit Calculation.

For the purposes of this **Temporary Total Disability** Benefit, **Average Weekly Earnings (AWE)** will be calculated as follows:

- If **You** are a Class I **Owner-Operator**:

  Thirty-three percent (33%) of the gross income **You** received from **Your** occupation in the tax year prior to the **Covered Accident** as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents, divided by 52, regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during such time period, then thirty-three percent (33%) of the gross income received as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents, divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked, if **You** are claiming less than fifty (50) weeks.

- If **You** are a Class II **Contract Driver**:

  Seventy-five percent (75%) of the gross income **You** received from **Your** occupation in the tax year prior to the **Covered Accident** as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by 52 regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during such time period, then seventy-five percent (75%) of the gross income received as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked if **You** are claiming less than fifty (50) weeks.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the tax year prior to the **Covered Accident** but have worked as an **Owner-Operator** or **Contract Driver** for at least twenty-six (26) weeks in the year of the **Covered Accident**, **We** will divide the gross income earned during such time period by the number of weeks worked. **You** will have to produce proof, which is satisfactory to **Us**, of **Your** gross income and the number of weeks worked.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the tax year prior to the **Covered Accident** and have not worked as an **Owner-Operator** or **Contract Driver** for at least twenty-six (26) weeks in the year of the **Covered Accident**, **We** will award **You** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

We reserve the right to require the production of the federal income tax return for the tax year prior to the **Covered Accident** consistent with the filing requirements for that tax year.

TTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Temporary Total Disability Benefit** will be reduced by: (1) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your** Disability; (2) Social Security Retirement Benefits; (3) Individual or Group Disability Benefits; (4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; (5) the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and (6) any income from employment or services, or from leasing **Your** power unit. **You** must provide federal income tax schedules and returns to **Us** for the purpose of calculating this offset.

TTD Benefit Termination.

The **Temporary Total Disability** Benefit will cease on the earliest of the following dates:

1. the date **You** are no longer **Temporarily Totally Disabled**;
2. the date the **Maximum Benefit Period** shown in the **Schedule** has been reached;
3. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**; or
4. the date **You** die.

TTD Benefit Definitions.

As used in this **Temporary Total Disability** Benefit:

Benefit Week means a 7-day period of time that begins on the first day of **Temporary Total Disability** after the **Waiting Period** shown in the **Schedule** for **Temporary Total Disability**, and on the same day of each week thereafter.

Continuous Care means monthly monitoring and/or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Temporary Total Disability** on a monthly basis unless **We** agree to a longer period.

Disability Commencement Period means the time period, shown in the **Schedule**, between the date of the **Accident** that caused the **Injury** and the date that **Temporary Total Disability** must begin for disability benefits to be payable under the **Policy**.

Maximum Benefit Period means, with respect to **Temporary Total Disability**, the maximum period for which benefits will be payable for a **Temporary Total Disability Covered Loss** during a **Single Period of Total Disability**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Temporary Total Disability** is shown in the **Schedule**.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following which are considered separate periods of disability: (1) successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which **You** are not **Temporarily Totally Disabled**; (2) successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least 6 months during which **You** are not **Temporarily Totally Disabled**.

Temporary Total Disability or **Temporarily Totally Disabled** means disability that: (1) prevents **You** from performing the **Material and Substantial Duties** of **Your** occupation as a commercial truck driver; (2) requires the care and treatment of a **Physician**; and (3) requires that, and results in, **You** receiving **Continuous Care**. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** will not qualify for the **Temporary Total Disability** Benefit.

For purposes of this section "**Material and Substantial Duties**" will mean a duty or duties which **You** are required to perform as an **Owner-Operator** or **Contract Driver**.

CONTINUOUS TOTAL DISABILITY (CTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

CTD Benefit Qualifications.

If a **Covered Injury** to **You** resulting in **Temporary Total Disability**, subsequently results in **Continuous Total Disability**, **We** will pay the **Continuous Total Disability** Benefit specified below, provided:

1. the benefits payable for the **Temporary Total Disability Covered Loss** ceased solely because the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached, but **You** remain disabled;
2. **You** are under the normal Social Security retirement age, as determined by federal law, on the day after the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached;
3. **You** have been granted a Social Security Disability Award for **Your** disability (If **You** cannot meet the credit requirement for a Social Security Award, **You** cannot qualify for the **Continuous Total Disability** Benefit even if **You** would otherwise qualify);
4. **Your** disability is reasonably expected to continue without interruption until **You** die, and is substantiated by objective medical evidence satisfactory to **Us**;
5. the **Injury** began within the **Disability Commencement Period** shown in the **Schedule**; and
6. the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**. (If the **Temporary Total Disability** was principally due to a **Mental and Nervous or Depressive Condition**, **You** do not qualify for a **Continuous Total Disability** Benefit.)

You cannot qualify for a **Continuous Total Disability** Benefit unless **You** qualified for a **Temporary Total Disability** Benefit for the same **Covered Injury**.

Sunset Period: If **You** are not granted a Social Security Award for **Your** disability within two (2) years of the **Injury**, **You** cannot qualify for a **Continuous Total Disability** Benefit even if **You** would otherwise qualify.

CTD Benefit Amount.

The **Weekly Benefit Amount** will be the lesser of the benefit percentage, as shown in the **Schedule**, of **Your Average Weekly Earnings (AWE)**, or the **Maximum Weekly Benefit Amount** as shown in the **Schedule**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Continuous Total Disability** Benefit with respect to less than a full **Benefit Week** of **Continuous Total Disability** equals 1/7th of the **Weekly Benefit** for each day of **Continuous Total Disability**.

CTD Benefit Calculation.

For purposes of this **Continuous Total Disability** Benefit, **Average Weekly Earnings (AWE)** will be calculated as follows:

- If **You** are a Class I **Owner-Operator**:

  Thirty-three percent (33%) of the gross income **You** received from **Your** occupation in the tax year prior to the **Covered Accident** as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents, divided by 52, regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during such time period, then thirty-three percent (33%) of the gross income received as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents, divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked if **You** are claiming less than fifty (50) weeks.

- If **You** are a Class II **Contract Driver**:

  Seventy-five percent (75%) of the gross income **You** received from **Your** occupation in the tax year prior to the **Covered Accident** as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by 52 regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during such time period, then seventy-five percent (75%) of the gross income received as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked, if **You** are claiming less than fifty (50) weeks.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the tax year prior to the **Covered Accident** but have worked as an **Owner-Operator** or **Contract Driver** for at least twenty-six (26) weeks in the year of the **Covered Accident**, **We** will divide the gross income earned during such time period by the number of weeks worked. **You** will have to produce proof, which is satisfactory to **Us**, of **Your** gross income and the number of weeks worked.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the tax year prior to the **Covered Accident** and have not worked as an **Owner-Operator** or **Contract Driver** for at least twenty-six (26) weeks in the year of the **Covered Accident**, **We** will award **You** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

We reserve the right to require the production of the federal income tax return for the tax year prior to the **Covered Accident** consistent with the filing requirements for that tax year.

CTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Continuous Total Disability Benefit** will be reduced by: (1) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your Disability**; (2) Social Security Retirement Benefits; (3) Individual or Group Disability Benefits; (4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; (5) the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and (6) any income from employment or services, or from leasing **Your** power unit. **You** must provide federal income tax schedules and returns to **Us** for the purpose of calculating this offset.

CTD Benefit Termination.

The **Continuous Total Disability** Benefit will cease on the earliest of the following dates:

1. the date **You** are no longer **Continuously Totally Disabled**;
2. the date **Your** Social Security Disability Award ceases;
3. the date **You** attain age 70;
4. the date the **Maximum Benefit Period** shown in the **Schedule** for **Continuous Total Disability** has been reached;
5. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**;
6. the date **You** die; or
7. the date the **Maximum Benefit Amount** shown in the **Schedule** for **Continuous Total Disability**, if any, has been reached.

CTD Benefit Definitions.

As used in this **Continuous Total Disability** Benefit:

Benefit Week means a 7-day period of time that begins on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Care means at least quarterly monitoring and/or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Continuous Total Disability** on a quarterly basis unless **We** agree to a longer period. These requirements may be waived by **Us**.

Continuous Total Disability or **Continuously Totally Disabled** means disability that: (1) prevents **You** from performing the duties of any occupation for which **You** are qualified by reason of education, training or experience; (2) requires the care and treatment of a **Physician**; and (3) requires that, and results in, **You** receiving **Continuous Care**. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** will not qualify for a **Continuous Total Disability** Benefit.

In addition to the requirements set forth above, if **You** can perform an occupation which would provide an annual gross income equal to or greater than either the gross income from wages and/or the net income reported on Schedule C which **You** filed on **Your** most recent federal income tax return filed prior to the **Covered Injury**, **You** are not **Continuously Totally Disabled**. **You** must provide **Us** with such federal income tax return in order to qualify for a **Continuous Total Disability** Benefit.

Maximum Benefit Amount, if any, means, with respect to **Continuous Total Disability**, the maximum benefits payable for **Continuous Total Disability Covered Losses**.

Maximum Benefit Period means, with respect to **Continuous Total Disability**, the maximum period for which benefits will be payable for a **Continuous Total Disability Covered Loss**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Continuous Total Disability** is shown in the **Schedule**. Benefits payable under the **Temporary Total Disability** Benefit will not be considered **Continuous Total Disability** Benefits for purposes of applying the **Maximum Benefit Period**.

Terms used in this **Continuous Total Disability** Benefit, but which refer to **Temporary Total Disability** and are defined in the **Temporary Total Disability** Benefit, are to be interpreted as defined in that Benefit.

ACCIDENT MEDICAL EXPENSE (AME) BENEFIT

AME Benefit Qualifications.

If **You** suffer an **Injury** that requires **You** to be treated by a **Physician**, within the **Medical Commencement Period** shown in the **Schedule**, **We** will pay the **Usual and Customary Charges** incurred for **Medically Necessary Covered Accident Medical Services** received due to that **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** shown in the **Schedule**, for **You**, for all **Injuries** caused by a single **Covered Accident**, subject to any applicable **Deductible Amount**.

The **Medical Commencement Period** starts on the date of the **Accident** that caused such **Injury**. The **Deductible Amount** for the **Accident Medical Expense** Benefit is the **Deductible Amount** shown in the **Schedule**, if any, which must be met from **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services** incurred due to **Injuries You** sustained in that **Covered Accident**.

AME Benefit Covered Accident Medical Services.

1. **Hospital** semi-private room and board (or room and board in an intensive care unit), **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room), or use of an **Ambulatory Medical Center**;
2. Services of a **Physician** or a qualified nurse, if under the supervision of a Graduate Registered Nurse (RN), for **Home Health Care** which follows a five (5) day period of **Hospital** confinement and which is prescribed by a **Physician**;
3. Services by a qualified **Physician** for the treatment of a covered **Mental and Nervous Condition** due to a **Covered Injury**. However, such charges will be considered a **Covered Accident Medical Expense** only to the extent that the charges do not exceed $25.00 per visit and are further limited to one (1) visit per day with a maximum of twenty (20) visits. **Hospital** charges for in-patient treatment of a **Mental and Nervous Condition**, whether in a psychiatric **Hospital** or a general **Hospital**, will be considered a **Covered Accident Medical Expense** and will be limited to up to a maximum of $1,000 for any one (1) **Accident**;

4. Ambulance, including air ambulance, service to or from a **Hospital** as stated in the **Schedule**;
5. Laboratory tests;
6. Radiological procedures;
7. Anesthetics and the administration of anesthetics;
8. Blood, blood products and artificial blood products, and the transfusion thereof;
9. Physical Therapy, Occupational Therapy, Work Hardening Therapy and Chiropractic or Acupuncturist Care as shown in the **Schedule**;
10. Rental of **Durable Medical Equipment**, up to the actual purchase price of such equipment;
11. The initial supply, but not replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes subject to the **Accident Medical Expense** Benefit Exclusions section;
12. Medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
13. Repair or replacement of **Sound Natural Teeth** damaged or lost as a result of a **Covered Injury**, up to the Dental Maximum, if any, shown in the **Schedule**;
14. **Extended Care Facilities**; and
15. **Home Health Care**.

The foregoing **Covered Accident Medical Services** are subject to all of the limits as shown in the **Schedule**.

AME Benefit Exclusions.

In addition to the GENERAL EXCLUSIONS in SECTION VI of the **Policy** and this **Certificate**, charges for **Covered Accident Medical Services** do not include, and benefits are not payable with respect to, any expense for or resulting from:

- repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
- dentures, bridges, dental implants, or treatment not related to the **Injury**;
- eye glasses or contact lenses not related to the **Injury**;
- hearing aids or hearing examinations not related to the **Injury**;
- that portion of rental expense for **Durable Medical Equipment** that exceeds the usual purchase cost for similar equipment in the locality where the expense is incurred;
- **Custodial Services**;
- **Personal Comfort** or **Convenience Items**;
- services of a Federal, Veteran's, State or Municipal **Hospital** for which **You** are not liable for payment;
- services or treatment which is covered by Medicare;
- that portion of the fee for services or treatment which is more than the **Usual and Customary Charge**;
- cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of an **Injury**;
- services or treatment which are provided for in a settlement or court judgment;
- services or treatment for which **You** are not legally obligated to pay;
- an **Extended Care Facility** stay that does not follow a **Hospital** confinement of five (5) days or more;
- any mileage charges related to the **Covered Injury** unless authorized by **Us**;
- any translation charges related to the **Covered Injury** unless authorized by **Us**;
- any lodging charges related to the **Covered Injury** unless authorized by **Us**; or
- services or treatment which are covered under any other insurance of any kind.

AME Benefit Definitions.

As used in this **Accident Medical Expense** Benefit:

Ambulatory Medical Center means a facility that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;

2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility. An **Ambulatory Medical Center** does not include a **Hospital** or a **Physician's** office or a clinic.

Custodial Services means any services which are not intended primarily to treat a specific **Injury**. **Custodial Services** include, but will not be limited to, services: (1) related to watching or protecting **You**; (2) related to performing or assisting **You** in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and (3) that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment refers to equipment of a type that is designed primarily for use, and used primarily by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Extended Care Facility means an institution that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;
2. is approved by the Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a Graduate Registered Nurse (RN);
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment for **You** in **Your** home as part of an overall extended treatment plan. To qualify, the extended treatment plan must:

1. be approved in writing by the attending **Physician**;
2. be provided by a **Hospital** certified to provide **Home Health** services or by a certified **Home Health Care** agency;
3. begin within seven (7) days after discharge from a **Hospital**; and
4. follow a **Hospital** confinement of five (5) days or more.

No benefits are payable for **Home Health Care** services provided by:

1. a member of **Your** immediate family; or
2. a person residing in **Your** home.

Hospital means a facility that: (1) operates under the law of the state that it is situated in; (2) is approved by the Department of Health and Human Services or its successor; (3) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (4) has 24-hour nursing service by graduate registered nurses (RN), on duty or on call; and (5) is supervised by one or more **Physicians**. A **Hospital** does not include: (1) a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the **Hospital** that is used for such purposes; or (3) any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Maximum Benefit Period means, with respect to the **Accident Medical Expense** Benefit, the maximum period for which benefits will be payable for **Covered Accident Medical Services** for or in connection with a single **Accident Medical Expense Covered Loss**. The length of the **Maximum Benefit Period** for **Accident Medical Expense** is shown in the **Schedule**.

Medical Commencement Period means the time period shown in the **Schedule** between the date of the **Accident** that caused the **Injury** and the date that the first medical service or treatment must be incurred for **Accident Medical Expense** Benefits to be payable under the **Policy**.

Medically Necessary means that a **Covered Accident Medical Service**: (1) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a **Physician** and performed under his or her care, supervision or order. The fact that a **Physician** may prescribe, authorize, or direct a service does not of itself make it **Medically Necessary** or covered by the **Policy**.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary** for the care and treatment of **Your Injury**. The term **Personal Comfort or Convenience Item(s)** includes, but is not limited to: (1) a private **Hospital** room, unless **Medically Necessary**; (2) television rental; and (3) **Hospital** telephone charges.

Sound Natural Teeth means natural teeth that are either unaltered or fully restored to their normal function and are disease free, have no decay, and are not more susceptible to **Injury** than unaltered natural teeth.

Usual and Customary Charge(s) means a charge that is made for a **Covered Accident Medical Expense** Benefit that: (1) does not include charges that would not have been made if no insurance existed; (2) is the lesser of the usual charges for similar services, treatment, supplies, or **Hospital** room and board in the locality where the expense is incurred, or the Workers' Compensation fee schedule, if applicable, or the negotiated rate of the **Preferred Provider** designated by **Us**. For a **Hospital** stay, the **Usual and Customary Charge** is based upon the expense for a semi-private room and board charge, unless the stay is a **Medically Necessary** stay in an intensive care unit; and (3) with respect to drugs, is the negotiated rate of the **Preferred Provider** designated by **Us**, if applicable, or 125% of the Average Wholesale Price (AWP), if applicable.

Unless there is a negotiated rate with the provider for a service, treatment, or supply, or unless otherwise noted, **We** will use the local workers' compensation schedule, if applicable, as the basis for the **Usual and Customary Charge**. All services and treatment must be due to a **Covered Injury**.

TRAVEL ASSISTANCE

Travel Assistance will be available to the following **Covered Persons** when they are traveling 100 miles or more from the **Insured Person's Principal Residence**: the **Insured Person** and his or her **Spouse**/**Domestic Partner** and/or **Dependent Child(ren)**, if the **Spouse**/**Domestic Partner** and/or **Dependent Child(ren)** are with the **Insured Person** while he or she is covered under this **Policy**. The **Spouse**/**Domestic Partner** and/or **Dependent Child(ren)** will not be covered while making a trip without the **Insured Person**. The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. However, for certain expenses, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $500. Under this **Policy**, **Travel Assistance** 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 the appropriate medical care required for such **Injury** or **Illness**, **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. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $500. 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.

  Assisted Return of Covered Person
  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the **Insured Person's Principal Residence**, in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $500. 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, if required, which are covered.

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. However, if it is not reasonably practicable for the legal representative or next of kin to contact **Us** for pre-authorization, such person may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $500.

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, the transportation for the person chosen by the **Covered Person** to visit such **Covered Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $500.

Return of Child
If an **Insured Person** is **Injured** or **Ill** while traveling with his or her **Dependent Child(ren)** on a **Covered Trip**, causing such **Dependent Child(ren)** to be left unattended, **We** will arrange and pay for the transport of the **Dependent Child(ren)** and for an attendant, if applicable. They will be transported to the location chosen by the **Insured Person**. **We** must pre-authorize the transportation of the **Dependent Child(ren)** and attendant, if applicable, for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $500.

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** such **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the companion's return. **We** must pre-authorize such costs for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $500.

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VI 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 deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions;
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with appropriate medical care required for such **Injury** or **Illness**. **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 ASSISTED 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. However, for certain expenses, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $500.

- **TRAVEL ASSISTANCE DEFINITIONS**

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

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

  Domestic Partner means a person with whom the **Insured Person** has a legally recognized relationship as a Domestic Partner, Civil Union Partner, Reciprocal Beneficiary, or a person who has registered in a state or local Domestic Partner registry with an **Insured Person**.

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

  Principal Residence means the legal domicile of the **Insured Person.**

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

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

  Right of Recovery
  We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder**, its **Designee**, or the **Insured Person** recovers any money from a third party for the expenses incurred by the applicable party that were covered under **Travel Assistance**. **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 **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance.**

  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 or in any country for which a travel warning has been issued by the Department of State of the United States of America.

  Scope
  Illness, as covered under **Travel Assistance,** is solely covered under **Travel Assistance,** and in no way supersedes or modifies the other **Coverages** provided under the **Policy**. All other **Coverages** provided under the **Policy** are available only as a result of a **Covered Injury**.

To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call 1-866-670-6693 from the U.S. or Canada; and collect from anywhere else in the world at +1-973-630-6693.

SECTION V – LIMITATIONS

Combined Single Limit.

We will not pay more than the **Combined Single Limit** stated in the **Schedule**.

Aggregate Limit of Liability.

We will not pay more than the **Aggregate Limit of Liability** stated in the **Schedule**.

Incarceration Limitation.

Benefits being made to **You** will cease while **You** are incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when **You** are released from such facility.

SECTION VI – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused in whole or in part by, or results in whole or in part from:

- suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**, including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of autoeroticism or auto-erotic asphyxiation; or any **Injury** resulting from a provoked attack;
- 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;
- **Cumulative Trauma** and/or **Repetitive Conditions**, unless as shown in the **Schedule**;
- **Occupational Disease**, unless (and to the extent as) specifically provided by this **Policy**;
- Hernia of any kind, unless as shown in the **Schedule**;
- Hemorrhoids of any kind, unless as shown in the **Schedule**;
- performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshore and Harbor Workers' Act, or similar coverage;
- war, or any act of war, whether declared or undeclared;
- involvement in any type of active military service;
- any **Injury** for which **You** are entitled to benefits pursuant to any Workers' Compensation Law or other similar legislation;
- any loss insured by employers' liability insurance;
- **You** being intoxicated. **You** are conclusively deemed to be intoxicated if the level of alcohol in **Your** 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 if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle, when the **Injury** occurs. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication;
- the deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions;
- participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot;
- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if **You** are:
  - **a.** riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - **b.** performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft;
  - **c.** riding as a passenger in an aircraft owned, leased or operated by the **Participating Organization** or an **Insured Person**;
- participation in any of the following activities:

skydiving	hang gliding	parachuting	parasailing
automobile racing or stunts	bungee-jumping	scuba diving	heli-skiing
motorcycle racing or stunts	endurance tests	fire fighting	racing
acrobatic or stunt flying	extreme sport stunts	hunting	

  flight on a rocket-propelled or rocket launched aircraft

  or any other extra-hazardous activity;
- a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**;
- alcoholism or drug addiction or the use of any drug or narcotic except as prescribed by a **Physician** operating within his or her scope of authority; or
- any **Pre-Existing Condition** until **You** have been continuously covered under the **Policy** for twelve (12) consecutive months.

SECTION VII – CLAIMS PROVISIONS

Notice. **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the loss within twenty (20) days of such loss. The notice must include **Your** name and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 866-568-2233. The notice must be sent to the Claims Department at Atlantic Specialty Insurance Company, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. **We** will send the claimant Proof of Loss (claim) forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the forms 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 loss. **We** will accept this report as a Proof of Loss if sent within the time fixed below for filing a Proof of Loss. The notice should include **Your** name, the **Participating Organization's** name, and the **Policy** number.

Proof of Loss. Written Proof of Loss, acceptable to **Us**, must be sent within ninety (90) days of the date of the loss. If the loss is one for which the **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as **We** may reasonably require. Failure to furnish Proof of Loss, acceptable to **Us**, within such time, will neither invalidate nor reduce any claim if it is not reasonably possible to furnish the Proof of Loss, and the proof is provided as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. **We** have a right to investigate the Proof of Loss and any relevant documents which **You** will make available to **Us** upon request.

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 one (1) 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**.

Recipient of Payment.

1. Loss of Life. **Covered Losses** resulting from **Your** death are paid to **Your** named beneficiary at the time of death. If there is no beneficiary named or **Your** 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;
   b. **Your** child(ren);
   c. **Your** parents;
   d. **Your** brothers and sisters;
   e. **Your** estate.
2. All Other Claims. Benefits are paid to **You**. **You** may direct in writing that all or part of an **Accident Medical Expense** Benefit be paid directly to the party who furnished the service. **You** may change the direction at any time up to the filing of the Proof of Loss. If **You** die before all payments due have been made, the amount still payable will be paid to **Your** beneficiary, or if there is no beneficiary designated, as set forth above.

Physical Examination and Autopsy. We have the right to examine **You** if **Your Injury** is the basis of a claim, when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** may also require an autopsy be performed, unless forbidden by law.

Conditional Claim Payment. If **You** suffer a **Covered Loss(es)** as the result of **Injuries** for which a third party may be liable, **We** will pay the amount of benefits otherwise payable under the **Policy**. However, if **You**, **Your** beneficiary or any other person receive payment from the third party, **You**, **Your** beneficiary or any other person agree to refund to **Us** the lesser of: (1) the amount actually paid by **Us** for such **Covered Loss(es)**; or (2) an amount equal to the sum actually received from the third party for such **Covered Loss(es)**. If **You**, **Your** beneficiary or any other person do not receive payment from the third party for such **Covered Loss(es)**, **We** reserve the right to subrogate under the Subrogation clause of the **Policy**.

At the time such third party liability is determined and satisfied, this amount will be paid whether determined by settlement, judgment, arbitration or otherwise. This provision will not apply where prohibited by law.

Rehabilitation. **We** will consider a rehabilitation program for **You** if **You** are receiving benefits under either the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit. The program must be mutually agreed upon by **You** and **Us**. The extent of **Our** participation will be determined by mutual agreement and benefits payable will continue during **Your** rehabilitation.

Sunset. In no event will a claim made for losses **You** sustained be considered valid and collectible in accordance with the **Policy** unless full details of such claim are presented to **Us** within five (5) years from the date of the **Accident** which is the basis of such claim.

Right to Recover Overpayments. In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to **You** (and **Your** assignee) under the **Policy** to the extent of the overpayment.

Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written Proof of 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, Wisconsin and Alabama) of the date the written Proof of Loss was required to be submitted. If the law of the state where **You** live 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.

Arbitration. Any contest to a claim denial and/or any dispute in connection with a claim under the **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to **You** or the person claiming to be **Your** beneficiary. This provision does not apply if **You** or the person claiming to be **Your** beneficiary is a resident of a state where the law does not allow binding arbitration in an insurance policy, but only if the **Policy** is subject to its laws and not pre-empted by the Federal Arbitration Act. In such a case, binding arbitration does not apply.

This Arbitration provision permanently bars the institution of any individual or class action lawsuit brought by **You** or **Your** beneficiary. With this binding Arbitration provision, **You**, for **Yourself** or **Your** beneficiary, are waiving the right to a trial by jury.

Recovery. In the event **You** make a recovery from a third party for a loss paid under the **Policy**, **You** will reimburse **Us** up to the amount of the benefits made by **Us**.

Subrogation. **We** have the right to recover all payments including future payments, which **We** have made, or will be obligated to pay in the future, to **You**, **Your** beneficiary or any other person from anyone liable for the **Covered Injury**. If **You**, **Your** beneficiary or any other person recover from anyone liable for the **Covered Injury**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to **You**, **Your** beneficiary or any other person. **You**, **Your** beneficiary or any other person agree to assist **Us** in preserving **Our** rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by **Us**.

Claims for Workers' Compensation and Other Insurance. No benefits will be payable under this **Policy** for any loss which **You** claims or file under any Workers' Compensation, employers' liability, occupational disease or similar law or insurance until such claim or filing is approved or denied. If such claim is denied and not appealed, **We** will pay benefits in accordance with the terms and provisions of this **Policy**. If such claim is denied, and **You** appeal the denial, no benefits will be paid under this **Policy** until a final disposition of the appeal is issued. If the final disposition is an approval of the claim, **We** reserve the right to recover, from **You**, any benefits paid under this **Policy** which are subsequently paid for under any Workers' Compensation, employers' liability, occupational disease or similar law or any other insurance. If the final disposition is a denial of the claim, **We** will pay benefits in accordance with the terms and provisions of this **Policy**.

SECTION VIII – GENERAL PROVISIONS

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. 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**.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at **Our** option, to any relative by blood or connection by marriage of the payee, who, in **Our** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

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.

Clerical Error. A clerical error or omission, whether by the **Policyholder**, or its **Designee**, or **Us**, 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**.

Conformity With Statute. Terms of the **Policy** that conflict with the laws of the District of Columbia are amended to conform to such laws.

Assignment of Interest. The **Policy** is non-assignable.

Incontestability. The validity of the **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.

Noncompliance With Policy Requirements. Any express waiver by **Us** of any requirements of the **Policy** will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

Offset Debt. We will have, and may exercise at any time, the right to offset any balance or balances, whether on account of premiums or otherwise, due from **You** to **Us** against any balance or balances, whether on account of losses or otherwise, due from **Us** to **You**.

SECTION IX – GENERAL DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, external event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Accident Commencement Period** means the time period, shown on the **Schedule**, between the date of the **Accident** which caused the **Injury** and the date the **Covered Loss** must occur for death, dismemberment or paralysis benefits to be payable under the **Policy**.
- **Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the **Policy**. 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 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 **Occupational Accident** Insurance **Certificate**.

- **Combined Single Limit** means, with respect to any one **Insured Person**, the total amount of benefits that are payable under the **Policy** for or in connection with a **Covered Injury** sustained as the result of any one **Covered Accident**. The **Combined Single Limit** shall also include the loss adjustment expenses incurred by **Us**. The loss adjustment expenses shall include but are not limited to fees, charges and costs for nurse case management, independent medical examinations, functional capacity examinations, vocational assessments and the processing and/or negotiation of **Hospital**, **Physician** and other provider charges. When the **Combined Single Limit** has been reached, no further benefits will be payable under the **Policy**, with respect to that **Insured Person** for or in connection with an **Injury** sustained as the result of that one **Covered Accident**.
- **Contract Driver** is as described in SECTION I.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while **You** are insured under the **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.
- **Cumulative Trauma** and/or **Repetitive Conditions** means conditions which impair the normal physiological function of the body over an extended period of time, and which do not arise as the result of a single **Accident**.
- **Deductible Amount** means the portion of the **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services**, incurred due to **Injuries You** sustain in a **Covered Accident**, which must be met before the **Accident Medical Expense** Benefit will be paid. The **Deductible Amount** is shown in the **Schedule**.
- **Dependent Child(ren)** means **Your** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children, from the date of the final decree of adoption, who rely on **You** for more than 50% of their support and are taken as dependents on **Your** Federal Income Tax Return, and who are either: 1) less than nineteen (19) years of age; or 2) less than twenty-three (23) 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 age twenty-three (23), became incapable of self-sustaining employment by reason of mental retardation or physical handicap. **We** may require proof of such **Dependent Child(ren)'s** incapacity and dependency.
- **Designee** is any person acting on behalf of the **Trustee**. For purposes of the **Policy**, there is one (1) **Designee**: the **Participating Organization.**
- **Dispatch** means when **You** are:
  1. in route to pick up a load;
  2. picking up a load;
  3. in route to deliver a load;
  4. unloading a load;
  5. in route after dropping off a load;
  6. waiting for a load if **You** are not at home;
  7. required to perform services by or for a motor carrier; or
  8. performing activities to comply with the laws of the United States (whether federal, state or territories) to satisfy motor carrier or commercial driving requirements.

  Dispatch must be authorized by the **Participating Organization**. **Dispatch** does not include an **Injury** during usual travel between, to, and from work or a bona fide leave of absence or vacation.

  For purposes of the **Policy**, if **You** are performing maintenance and/or repairs on a power unit which **You** own or lease, **You** will be deemed to be under **Dispatch**. **You** must provide proof which is satisfactory to **Us** that the **Injury** was sustained while performing such maintenance or repairs in order to receive **Occupational Accident Benefits** for the **Injury**.
- **Eligible Person** means a person who is described in the ELIGIBILITY portion of SECTION I.
- **Immediate Family Member** means a person who is related to **You** in any of the following ways: **Spouse**, domestic partner or civil union partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or placed for adoption, or stepchild) or any person residing in **Your** home.

- **Injury** or **Injuries** means bodily harm or bodily damage.
- **Insured Person** means a person who: (1) is an **Eligible Person** as described in the ELIGIBILITY portion of SECTION I; (2) has enrolled for coverage; and (3) has coverage in effect according to the terms of the **Policy**.
- **Mental and Nervous** or **Depressive Condition** means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.
- **Non-Occupational** means an activity involving **You**, which occurs while **You** are not under **Dispatch**.
- **Non-Occupational Accident Benefits** means the benefits **We** will pay for **Non-Occupational Covered Losses** as shown in the **Schedule**.
- **Occupational** means an activity involving **You** while **You** are under **Dispatch**. **Occupational** does not encompass any period of time during the course of everyday travel to and from work or while on vacation.
- **Occupational Accident Benefits** means the benefits **We** will pay for **Occupational Covered Losses** as shown in the **Schedule**.
- **Occupational Assessment** means a test of vocational capabilities. The process includes a review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.
- **Occupational Cumulative Trauma** and/or **Repetitive Conditions** means bodily **Injury** to **You** caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time, where: (1) such condition is diagnosed by a **Physician**; (2) **Your** performance of the activities causing the **Injury** occurred during the **Policy** period, and the onset of the **Injury** occurred and was reported during the **Policy** period; and (3) such activities resulted directly and independently of all other causes in a **Covered Loss**.
- **Occupational Disease** means a sickness which results in disability or death, and is caused by exposure to environmental or physical hazards during the course of **Your Occupational** activities, where: (1) such condition is diagnosed by a **Physician**, and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards; (2) exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which **You** perform **Occupational** services; (3) **Your** last day of last exposure to the environmental or physical hazards causing such condition occurs during the **Policy** period; and (4) such exposure results directly and independently of all other causes in a **Covered Loss**.
- **Owner-Operator** is as described in SECTION I. All references to the **Owner-Operator's** power unit will be deemed to include a power unit owned or leased by a corporation or limited liability company where the **Owner-Operator** is the principal shareholder or member.
- **Participating Organization** is the entity shown on page 2 of this **Certificate** as a participant in the Trucking Industry Group Insurance Trust.
- **Physician** means a practitioner of the healing arts acting within the scope of his or her license who is not: (1) **You**; or (2) **Your Immediate Family Member**; or (3) a practitioner retained by the **Participating Organization**.
- **Policy** means the **Occupational Accident** Insurance **Policy** upon which this **Certificate** is based.
- **Policyholder** is the **Trust** named as **Policyholder** on the front page of the **Policy** and this **Certificate**.
- **Pre-Existing Condition** means a condition for which **You** have sought or received medical advice or treatment during the twelve months immediately preceding **Your** effective date of coverage under the **Policy**.
- **Preferred Provider** means a **Physician** or **Hospital** with which **We** have an agreement or contract to perform a covered service or treatment at an agreed upon rate or a company which provides prescription drugs at an agreed upon rate to **You**. In the following situations only, a non-preferred provider that **You** use will be deemed to be a **Preferred Provider**:

  1. There is no **Preferred Provider** located within a 50-mile radius of **Your** legal residence and it is not reasonable to expect **You** to seek treatment or services from a **Preferred Provider**;
  2. **You** received treatment or services under **Emergency Conditions** and it would not have been reasonable to expect **You** to have sought treatment or services from a **Preferred Provider**; or
  3. The **Medically Necessary Accident Medical Services You** required are not available through a **Preferred Provider**.

For purposes of this provision, an **Emergency Condition or Conditions** is where a **Covered Injury**: 1) renders **You** unable to select a **Physician**, **Hospital**, or other health care provider; 2) requires an emergency responder to select a **Physician**, **Hospital**, or other health care provider without **Your** prior approval; or 3) requires immediate medical care in order to prevent irreparable bodily harm or death and the nearest qualified **Physician**, **Hospital**, or other health care provider is a non-preferred provider.

- **Principal Sum**, as applicable to **You**, means the amount of insurance in force under the **Policy** as described in the **Schedule**.
- **Schedule** is SECTION II of this **Certificate**.
- **Spouse** means **Your** legally married spouse.
- **Trust** is the Trucking Industry Group Insurance Trust established on October 27, 2011 with the SunTrust Bank as **Trustee**.
- **Trustee** is the SunTrust Bank located at 1445 New York Avenue, NW, Washington, DC 20005-2108.
- **Waiting Period** means the consecutive number of days **You** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit provisions of the **Policy**. **Benefits are not retroactive to the first day of disability.** The **Waiting Period** is shown in the **Schedule**.
- **We**, **Us**, and **Our** refers to Atlantic Specialty Insurance Company.
- **You** and **Your** refers to the **Insured Person**.

In Witness Whereof, We have caused the Policy to be executed and attested.

Christopher V. Jerry, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

EXHIBIT

The following Services will be provided to an Insured Person:

I. – IDENTITY MANAGEMENT SERVICES

Fraud Resolution Response:

- Dedicated Fraud Specialists work on behalf of the Insured Person to resolve an identity theft issue
- Monitoring Services provided following an identity theft
- Unlimited access to Crisis Resolution Center's toll free telephone number
- Assistance in filing a police report and scheduling an interview with the police
- Preparation of all documents and phone calls needed for creditor notification
- One full year of active follow-up after resolution is complete

Proactive Fraud Response:

- Fraud Alerts
- Pro-active assistance following theft or loss of wallet/purse (to minimize risk)
- Credit File Freezes

Life Stage Identity Management Services:

- Home & Auto Invasion – provides options to monitor and protect identity following an incident
- Infant and Minor Identity Risk Mitigation Response – helping parents protect their child's identity
- Deployed Military Personnel Response – defending those who defend our country
- Medical Identity Response – the medical identity theft remedy
- Surviving Spouse Response – safeguarding the identity of a deceased loved one
- Identity Travel Response – helping to recover lost or stolen documentation
- Relocating Residences Response – keeping one's identity safe during a move
- Catastrophic Event Document Replacement Response – helping disaster victims recapture critical documents
- Marriage and Divorce Response – guarding against identity theft during emotional periods of life

To access Identity Management Services call: 1-866-799-6695
and reference: Program #: 216-002-069
Group Code: OBAH

II. – TRAVEL ASSISTANCE SERVICES

Medical Travel Assistance Services (This is available to an Insured Person while he or she is traveling 100 miles or more from his or her Principal Residence. Also available to his or her eligible dependents provided such dependents are traveling with the Insured Person.)

- Worldwide referrals to appropriate medical and dental care
- Monitoring of treatment by Regional Medical Advisors
- Facilitation of hospital payments (upon receipt of guarantee to reimburse)
- Transfer of insurance information and medical records to medical providers
- Facilitation of hospital admission and discharge planning
- Obtaining medications, vaccines and blood where unavailable, or prescription medications if lost or stolen (provided it is legally permissible)
- Coordinating replacement of corrective lenses or medical devices if lost, stolen or broken
- Providing case updates to family, employer and/or home physician (with approval)
- Facilitation of hotel arrangements for convalescence
- Dispatch of doctors/specialists in special emergency situations

Personal Travel Assistance Services (This is available to an Insured Person while he or she is traveling 100 miles or more from his or her Principal Residence. Also available to his or her eligible dependents provided such dependents are traveling with the Insured Person.)

- Provision of pre-travel and health information such as: 1) culture, weather, currency and regional health concerns; 2) immunizations and vaccinations required; 3) entry and exit requirements; 4) transportation information
- Provision of real-time Security Intelligence for destination
- Facilitation of replacement of lost or stolen travel documents, such as tickets or passports
- Arrangement of emergency travel, including airlines and hotels
- Facilitation of transfer of emergency funds
- Legal referrals and assistance in obtaining bail bonds
- Emergency translation services or referrals to local interpreter services
- Transmission and receipt of emergency messages
- Coordinating emergency boarding for, and/or return of pet

To access Travel Assistance Services, call: Toll Free: 1-866-670-6693
Collect: 1-973-630-6693

DISTRICT OF COLUMBIA
SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

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

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

Coverage

The District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association"), established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 *et seq.*), provides insolvency protection for certain types of insurance policies and contracts. NOTE: Certain policies and contracts may not be covered or fully covered.

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

Coverage Limitations

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

- the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- with respect to any one life, regardless of the number of policies, contracts, or certificates:
    1. $300,000 in life insurance death benefits for any one life, including net cash surrender or net cash withdrawal values;
    2. $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
    3. $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
    4. $300,000 for long-term insurance care benefits;
    5. $300,000 for disability insurance;
    6. $500,000 for basic hospital, medical, and surgical insurance or major medical insurance;
    7. $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values.

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

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

Exclusions Examples

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

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

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits, or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Consumer Protection

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

Policy or contract holders with additional questions may contact either:

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

District of Columbia
Life and Health Guaranty Association

1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and statutory coverage protections. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any right established in any policy or contract, or under the Act.

Our Policy Regarding Your Privacy

In order to provide the insurance products and services that respond to our customers' diverse needs, OneBeacon Insurance Group collects certain personal information. OneBeacon Insurance Group does not disclose any nonpublic personal information to any affiliated or nonaffiliated third party for marketing purposes. At OneBeacon Insurance Group, maintaining the confidentiality of our customers' personal information is of the highest importance. OneBeacon Insurance Group personal information-handling practices are governed by this privacy policy and are further regulated by law. This notice describes those practices and how they preserve your privacy in a way that permits OneBeacon Insurance Group to provide you with the products and service you demand.

Collection of Personal Information

We get most of our information directly from you. The application you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. Depending on the nature of your insurance transaction, we may need additional information about you or other potential insureds from outside sources such as motor vehicle records, loss information reports, credit reports, court records or other public records. For property insurance, we may send someone to inspect your property and verify information about its value and condition, and a photo of the property may be taken.

We also may obtain information from third parties such as other insurance companies or consumer reporting agencies. A consumer report from such an agency may contain information as to credit worthiness and credit standing. If we order any kind of consumer report, upon request, we will tell you how to get a copy of the report. The agency preparing a consumer report for us may keep the information collected about you as permitted by law, and it may be disclosed to other persons.

Disclosure of Personal Information

Information which has been collected about you will be contained in either our policy records or in your producer's files. We review it in evaluating your request for insurance coverage and in determining your rates. We will also use information in our policy records for purposes related to issuing and servicing insurance policies and settling claims. OneBeacon Insurance Group may disclose personal information to others in order to service, process or administer business such as underwriting and claims operations. In this context, OneBeacon Insurance Group may disclose **(i)** information we receive from you on applications and other forms, including information such as assets, income, and identifying information such as name, address and social security number; **(ii)** transaction information such as information about balances, payment history and parties to the transaction; and **(iii)** information from consumer reporting agencies such as a consumer's credit worthiness and credit history.

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report, we will tell you as required by state law and the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report.

Parties to Whom Information May be Disclosed

OneBeacon Insurance Group will not disclose information about you to others without your written consent unless the disclosure is necessary to conduct our business. By law, OneBeacon Insurance Group is permitted to share information about you without prior permission under certain circumstances to certain persons and organizations such as:

- Your producer.
- Parties who perform a business, professional or insurance function for our company, including our reinsurance companies.
- Claim adjusters, appraisers, investigators and attorneys who need the information to investigate, defend or settle a claim involving you.
- Insurance support organizations which are established to collect information for the purpose of detecting and preventing insurance crimes and fraudulent claims.
- Insurance regulatory agencies in connection with the regulation of our business.
- Law enforcement or other governmental authorities to protect our legal interest, or in cases of suspected fraud or illegal activities.
- Authorized persons as ordered by subpoena, warrant or other court order or as required by law.
- Lien holder, mortgagee, assignee, lessor, or other person shown on our records or our producer’s as having a legal or beneficial interest in a policy of insurance.
- Parties acting in a fiduciary or representative capacity to you (attorneys, accountants and auditors).
- Insurance rate advisory organizations.
- Parties enforcing OneBeacon Insurance Group rights in connection with the settlement of a debt, the transfer of interests or an audit.
- Parties administering transactions as requested or authorized by you.

Right of Access to Personal Information

You have the right to know what kind of information we keep in our files about you, to have reasonable access to it and to receive a copy. Write to us if you have questions about the information. Provide your complete name, address, type of policy and policy number that was issued or applied for with us. Mail your request to: Privacy Administrator, Post Office Box 254, Canton, MA, 02021-0254. Certain types of information generally collected when evaluating claims or possible lawsuits need not be disclosed to you.

Within thirty (30) business days of receipt of your request, we will inform you in writing of the nature and substance of retrievable recorded personal information about you in our files. You may review this information in person or receive a copy by mail. We will also identify the person or organization to which we have disclosed this information within the past two (2) years. In addition, you will be given the name and address of any consumer reporting agency which prepared a report about you so that you can contact them for a copy.

After you have reviewed the personal information about you in our file, you can write to us if you believe it should be corrected, amended or deleted. We will consider your request, and within thirty (30) days either change the information or tell you that we did not and state the reason. If we do not make changes, you will have the right to insert in our file a concise statement containing what you believe to be the correct, relevant or fair information, and explaining which information on file you believe to be improper. We will notify persons designated by you to whom we have previously disclosed the information of the change or your statement. Subsequent disclosures we make also will include your statement.

Confidentiality and Security of Personal Information

Our company maintains appropriate standards and procedures to prevent unauthorized access to your information. OneBeacon Insurance Group limits employee access to personally identifiable information to those with a business reason for knowing such information. We educate our employees so that they will understand the importance of confidentiality of personal information and take appropriate measures to enforce privacy responsibilities.

Treatment of Personal Information of Former Customers

OneBeacon Insurance Group follows this personal information privacy policy even when a customer relationship no longer exists.

If you have additional questions about the privacy of your personal information or about your insurance needs in general, please contact your producer.

Effective July 1, 2001