Companion Life Insurance Company
7909 Parklane Road, Suite 200
Columbia, South Carolina 29223
(the "Company")

Policy No.: G4200 OP2 22982 Policy Effective Date: February 1, 2014

Policy Anniversary Date: February 1, 2015 and each February 1 thereafter

State of Issue: Texas

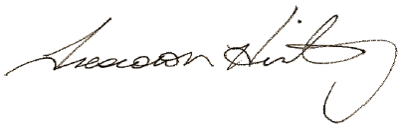
This policy is a contract between the Company and Bradley J. O'Keefe dba B.O.K. Works
(Herein Called the Policyholder)

In consideration of the application of the Policy holder, a copy of which is attached to and made a part of this Policy, and of the payment of premiums in the amounts and at the times provided, the Company agrees to pay the benefits provided, subject to all the provisions of this Policy.

This Policy takes effect on the Policy Effective Date, 12:01 A.M. Standard Time, at the Policyholder's address, and will, subject to the Termination provision, continue in effect as long as premium is paid. Policy years and months are determined from the Policy Anniversary Date. The Policy may be modified by mutual agreement between the Policyholder and Us.

IN WITNESS WHEREOF, the Companion Life Insurance Company has caused this Policy to be signed by its President at Columbia, South Carolina.

COMPANION LIFE INSURANCE COMPANY



President

GROUP SUPPLEMENTAL MEDICAL EXPENSE INSURANCE POLICY
RENEWABLE AT THE OPTION OF THE COMPANY
NON-PARTICIPATING

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

EMPLOYER APPLICATION

Administered by:
Special Insurance Services, Inc.
2740 Dallas Parkway, Suite 100
Plano, Texas 75093
Telephone Number: (972) 788-0699 or (800) 767-6811
Fax: (972) 960-0377

Underwritten by: Companion Life

Bradley J. O'Keefe dba

Application is hereby made by: BOK Works
(full name of organization/firm)

Type of Business: Software Development

Located at: 1100 Nasa Parkway, Suite 211C
Number Street

Houston, Texas 77058
City State Zip

E-Mail Address: nicoleighokeefe@gmail.com

(1) Insurance shall be:
Employee Only Cost: 50 % Employer Contribution 50 % Employee Contribution
Dependent Cost: 0 % Employer Contribution 100 % Employee Contribution

(2) Total number of employees: 2
Number of employees eligible for this plan: 2
Number of employees participating: 2
Percentage of participating employees: 100 %
Number of dependents to be covered: 1
*Include retirees who retire prior to age 65:
☒ Yes ☐ No
If yes, such retirees must be covered by Employer's Health Benefit Plan.
*Number of retirees to be covered: 0

Eligible employees include owners, partners, and executive officers.
Number of hours eligible employees must work per week: 30
(NOTE: Employee must work at least 30 hours a week.)

Include coverage for Domestic Partners: ☐ Yes ☒ No
(Domestic Partner means an adult who is in a committed relationship with an employee wherein the Domestic Partner and the employee are mutually responsible for one another financially and otherwise.)

(3) In-Hospital Plan of benefits requested for all employees: Plan I: $_____ Plan II: $5000
☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500
☐ $3,000 ☐ $3,500 ☐ $4,000 ☒ $5,000 ☐ Other: $_____
Outpatient Benefit: ☐ OPI ☒ OPII: Plan I: $_____ Plan II: $2500
☐ $200 ☐ $500 ☐ $1,000 ☐ $2,000 ☐ Other: $2500
Physician Benefit: Plan I: $_____ Plan II: $_____
☐ $15 visit up to the lesser of $120 or 8 visits per family, per Calendar Year
☐ $20 visit up to the lesser of $240 or 12 visits per family, per Calendar Year
Term Life and AD&D Rider: Plan I: $_____ Plan II: $_____
☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

(4) Critical Illness Benefit
Employee Benefit
☒ $5,000 ☐ $10,000

(5) Billing Method: ☒ Monthly List Bill (First Month Premium is due at time of application)

Billing Information:
Mailing/Billing Address: 1100 Nasa Parkway, Suite 211C
Houston, Texas 77058

Are multiple billings required? ☐ Yes ☒ No If yes, attach a list of each location and their physical address.

Mail Premium Notice to: ☒ Employer ☐ Third Party Payor*
**Third Party Payor is acting on behalf of the Employer and not the Insurance Company.*

Third Party Payor: _____
Mailing Address: _____
_____
Contact Person/Title: _____
Copy Agent on all correspondence? ☐ Yes ☒ No If No, all correspondence will be handled directly with the Employer.

The effective date of this insurance applied for will be the later of the first day of the month following the acceptance of employee Enrollment Forms by the Company and receipt of premium payment, or the Employee's effective date under the Employer's Health Benefit Plan.

Requested effective date for group: 2/1/2014

I understand that requests submitted to the Company for individual employee cancellation of coverage and return of premium, if any, must be signed by the employee.

The Policy forms will be delivered to the group electronically unless you request in writing to receive a paper copy. The Certificate package for distribution to all insureds will be delivered to you electronically unless you request in writing to receive a paper copy for distribution.

FRAUD WARNING NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signature of Employer _____ Title Owner Date 1/11/2014

Contact Person Nicole OKeefe Daytime Telephone No. 713-724-2349

EMPLOYER AUTHORIZATION

Direct Bill:

Organization/Firm BOK WORKS

Billing Address _____ City _____ State _____ Zip Code _____
(If different from the first page)

Employer's Signature _____

Agent Information:

Writing Agent Name John G. Sullivan

Agent Address P.O. Box 58858

E-Mail Address _____

Tax ID No. (If none, Social Security No.) 071-30-6045

Commission Paid To John G. Sullivan

Are you appointed with Companion Life Insurance Company? ☒ Yes ☐ No
If "No," contact Companion Life Insurance Company immediately regarding appointment.

CONTENTS

SCHEDULE

INPATIENT HOSPITAL BENEFIT per Insured Person	up to $5,000 per Calendar Year
OUTPATIENT BENEFIT II Per family, per Calendar Year Maximum Per Insured Person, per Calendar Year Maximum	 up to $5,000 50% of per family, Per Calendar Year
PHYSICIAN BENEFIT	Not Covered

All benefits listed above are subject to Exclusions and Limitations as outlined in the Policy.

DEFINITIONS

Calendar Year means the period that starts with the Insured Person's effective date and ends on December 31st of the first year. Each following Calendar Year will start on January 1st of any year and end on December 31st of that year.

Coinsurance means that dollar amount of covered medical expenses, after Deductible, not payable under the Insured Person(s) Health Benefit Plan.

Complications of Pregnancy means:

(a) a condition which, while affected by Pregnancy, is still classed by accepted medical standards as a Sickness, disease or Injury apart from the normal bodily changes that accompany Pregnancy;
(b) a non-elective cesarean section;
(c) an extrauterine or ectopic Pregnancy; or
(d) a spontaneous termination of Pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include: false labor, premature labor, high risk pregnancy or delivery, occasional spotting, Physician-prescribed rest, morning sickness, pre-eclampsia or placenta previa or similar conditions that occur in a difficult pregnancy.

Deductible means the dollar amount of Deductible that applies to all the covered medical expenses under the Insured Person(s) Health Benefit Plan.

Employee means a person employed by the Policyholder and meeting the minimum hourly requirements shown in the Policyholder's application. If the Employer is a proprietorship or partnership, the individual proprietor or each of the partners is an Employee only if engaged in the regular business of the Employer for the minimum hourly requirement shown in the Policyholder's application. No director of a corporate Employer is an Employee solely because of such directorship. Employee also includes a retiree, but only if a retiree class is requested by the Policyholder's application.

Employer means the Policyholder and includes any division, subsidiary or affiliated company wholly owned by the Policyholder and named in the Policyholder's application.

Expenses Incurred means the charge made for a service or supply that is covered by this Policy and given to an Insured Person due to an Injury or Sickness. The Expense Incurred must be Medically Necessary for the condition being treated. An expense or charge is deemed to be incurred on the date the service or supply that causes the expense or charge is given or obtained.

Health Benefit Plan means any group major medical or comprehensive medical plan through which an Insured Person has coverage. It may be a self-funded plan or provided through insurance. Health Benefit Plan does not include any limited medical program, Medicare, Medicaid, CHAMPUS, or TRICARE.

Home Office means the Company's office located at 7909 Parklane Road, Suite 200, Columbia, South Carolina 29223.

Hospital means a legally authorized and operated institution for the care and treatment of sick and injured persons. It must have graduate registered nurses (R.N.) on 24 hour call and organized facilities for diagnosis and surgery either on its premises or in facilities available to it on a contractual prearranged basis.

The following do not qualify as a Hospital: an institution, or part of it, which is used mainly as a facility for rest, nursing care, convalescent care, care of the aged, or for remedial education or training.

Hospital Confined/Hospital Confinement means the Insured Person is admitted to the facility as an overnight bed patient for a minimum of 15 consecutive hours.

Immediate Family means an Insured or an Insured Person's spouse, parent, child, grandparent, brother, sister, in-law or any person residing in the Insured Person's home.

Injury means bodily injury sustained by an Insured Person caused by an accident, directly and independently of all other causes, that occurs while this Policy is in force. All injuries sustained by an Insured Person in any one accident are considered a single Injury.

Insured Person means either an Insured or an Insured Dependent. An **Insured** is an Employee of the Policyholder whose coverage under the Policy has become effective and has not been terminated. **Insured Dependent** means any of the following:

(a) the Insured's spouse;
(b) the unmarried Dependent child or children of the Insured or of the Insured's spouse who are under 26 years of age; and
(c) the unmarried handicapped Dependent child of the Insured or of the Insured's spouse who has attained age 26, provided such child was an Insured Person on the day immediately prior to attaining age 26, is mentally handicapped or physically incapable of earning his or her own living. Proof of incapacity must be furnished to the Company, but not more than once in any 12-month period.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption, child under the Insured's legal guardianship, and grandchild who is a Dependent of the Insured for federal income tax purposes at the time the application for coverage of the grandchild is made. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

A spouse or child covered under the Policy as an Insured will not be eligible as a Dependent. If a husband and wife are both covered as Insureds, a child will be the Dependent of only one parent.

Medically Necessary means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

(a) it is provided only as a convenience to the Insured Person or provider;
(b) it is not appropriate treatment for the Insured Person's diagnosis or symptoms;
(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
(d) it is part of a plan of treatment that is experimental, unproven or related to a research protocol.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Policyholder means the Employer in whose name the Policy is issued, as shown on the cover page of the Policy.

Physician means a qualified licensed Physician other than an Insured Person or a member of his Immediate Family. Physician includes all providers of medical care and treatment to the extent that they are licensed to perform services provided in this Policy. This includes, but is not limited to, medical doctors, chiropodists, chiropractors, dentists, optometrists, osteopaths, podiatrists and psychologists.

Pregnancy means a pregnancy which is terminated by childbirth, other than an elective cesarean section; or an elective abortion.

Schedule means the schedule in the Policy or Certificate which contains the benefits provided by the Policy.

Sickness means a disease or illness, or more than one disease or illness, resulting from the same or related causes or conditions, including all complications thereof and all related conditions and recurrences resulting in medical expense insured under the Policy or otherwise resulting in a claim for benefits while the Policy is in force with respect to the Insured for whom the claim is made.

We means Companion Life Insurance Company. **Us, Our, Ours** and the **Company** also refers to Companion Life Insurance Company.

You, **Your** and **Yours** means the Insured.

ELIGIBILITY AND EFFECTIVE DATE

An Employee's Coverage will be effective as of the first of the month following approval of an eligible person's, as defined in the Policyholder's Application, individual application and payment of the first premium. In no event will coverage for any person become effective prior to the Effective Date of this Policy.

Newborn children, adopted children, children placed for adoption, or children for whom the Insured is a party in a suit for adoption will be covered on their date of birth, adoption, placement for adoption, or filing of such suit for a period of 31 days. If, during this 31 days, the Insured notifies the Company in writing and pays any premium that may be due, coverage will continue. If notification and premium payment is not received within the first 31 days after birth, adoption, placement for adoption, or filing of such suit evidence of insurability will be required and the Pre-Existing Condition Limitation, if any, will apply.

A congenital defect or birth abnormality of a newborn child which requires Hospital Confinement will be considered a Sickness.

LATE ENROLLEES

If You do not apply for coverage on Your initial eligibility date, You may not apply for coverage for Yourself and/or any Dependents until the next Policy Anniversary Date.

BENEFITS

The following benefits are payable if the Insured Person is covered by a Health Benefit Plan when the Covered Charges are incurred. Each benefit is subject to the terms, conditions, limitations, exclusions and Calendar Year Maximums as described herein.

Inpatient Hospital Benefit - If, as a result of an Injury or Sickness an Insured Person is Hospital Confined, under the regular care and attendance of a Physician and the expenses are covered by the Insured Person's Health Benefit Plan, the Company will pay up to the Inpatient Hospital Benefit per Calendar Year stated in the Policy Schedule. Hospital Confinement must begin on or after the Effective Date.

Such benefits are limited to:

(a) The Deductible the Insured Person is required to pay under his Health Benefit Plan.
(b) The Coinsurance amount the Insured Person is required to pay under his Health Benefit Plan.

Benefits also will be payable for Hospital emergency room treatment as follows:

(a) Injury – up to the Inpatient Hospital Benefit, subject to Exclusions, Limitations and the Other Insurance Provision.
(b) Sickness – up to the Inpatient Hospital Benefit, subject to Exclusions, Limitations and the Other Insurance Provision, if the Sickness results in Hospital Confinement within 24 hours of the Hospital emergency room treatment.

Outpatient Benefit II – Benefits are payable for Medically Necessary outpatient treatment for Injury or Sickness as shown in the Schedule. Such benefits are limited to: (a) the Deductible or Co-Payments the Insured Person is required to pay under his Health Benefit Plan; and (b) the Coinsurance amount the Insured Person is required to pay under his Health Benefit Plan. A "per Covered Person, per Calendar Year Maximum" equal to 50% of the Family Calendar Year Maximum also applies. Outpatient benefits include treatment under the regular care and attendance of a Physician at a Hospital, an outpatient surgical or emergency facility, a diagnostic testing facility, or a similar facility that is licensed to provide outpatient treatment. Covered expenses under the outpatient benefit do not include physician office visit expenses.

This benefit is in lieu of any Hospital Emergency Room benefit in the Inpatient Hospital Benefit.

EXCLUSIONS

Benefits will not be paid for losses caused by or resulting from any one or more of the following:

(a) Declared or undeclared war or any act thereof;
(b) Suicide or intentionally self-inflicted Injury or any attempt thereat, while sane or insane (while sane, in Colorado and Missouri);
(c) Any Hospital Confinement or other covered treatment for Injury or Sickness while an Insured Person is in the service of the armed forces of any country. Orders to active military service for training purposes of two months or less do not, for the purpose of this exclusion, constitute service in the armed forces of any country. Upon notification to the Company of entering the armed forces of any country, the Company will return to the Insured pro rata any premium paid, less any benefits which have been paid, for any period during which the Insured Person is in such service;
(d) Confinement in a Hospital or other covered treatment provided in a facility operated by an agency of the United States government or one of its agencies, unless the Insured Person is legally required to pay for the services;
(e) Confinement or other covered treatment for Injury or Sickness which is not Medically Necessary;
(f) Confinement or other covered treatment for Dental or Vision care not related to an accidental Injury;
(g) Mental or nervous disorders;
(h) Alcoholism, drug addiction or complications thereof;
(i) Any Hospital Confinement or other covered treatment for Injury or Sickness for which compensation is payable under any Worker's Compensation Law, any Occupational Disease Law, or similar legislation;
(j) Any Hospital Confinement or other covered treatment for Injury or Sickness that is payable under any insurance that does not require Deductible and/or Coinsurance payments by the Insured Person;
(k) Any Hospital Confinement or other covered treatment for Injury or Sickness for which benefits are not payable under the Insured Person's Health Benefit Plan;
(l) Any Hospital Confinement or other covered treatment for Injury or Sickness if, on the Insured Person's effective date of coverage, the Insured Person was not covered by a Health Benefit Plan, Our obligation will then be to refund all premiums paid for that Insured Person;
(m) An Insured Person engaging in any act or occupation which is a violation of the law of the jurisdiction where the loss or cause occurred. A violation of the law includes both misdemeanor and felony violations;
(n) Prescription drugs;
(o) Durable medical equipment, unless dispensed in a Hospital, an outpatient surgical or emergency facility, a diagnostic testing facility, or a similar facility that is licensed to provide outpatient treatment;
(p) Well newborn care, whether inpatient or outpatient; and
(q) Wellness or preventive care.

LIMITATIONS

Pregnancy. Hospital Confinements due to Pregnancy are payable if the Pregnancy is payable under the Insured Person's Health Benefit Plan.

Benefits for Pregnancy under this provision are limited to an Insured or an Insured Dependent spouse.

TERMINATION OF COVERAGE

Coverage will terminate on the earliest date any of the following events occur:

(1) As to any Insured Person:
  (a) On the date this Policy is terminated;
  (b) As of the premium due date when the required premium remains unpaid, subject to the grace period;
  (c) On the premium due date following the date the Insured ceases to be an Employee of the Policyholder; or
  (d) On the premium due date following the date the Insured Person's coverage under a Health Benefit Plan is no longer in effect.

(2) As to an Insured Dependent spouse:
  (a) On the premium due date following the date the spouse ceases to be an eligible spouse.

(3) As to Insured Dependent children:
  (a) On the premium due date following the date the child ceases to be an eligible child.

If a mental or physical handicap prevents an Insured Dependent child from self-support when he reaches the termination age, he may remain as an Insured Person under the Policy. Proof of such incapacity and dependency must be furnished to the Company within 31 days of the child's attainment of the termination age. Proof may be required by Us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Coverage will continue as long as coverage remains in force and the Insured Dependent child is incapable of self-support.

Termination of the insurance of any Insured Person will be without prejudice to any Hospital Confinement or other covered treatment for Injury or Sickness that begins before the date of termination.

PREMIUMS

Premiums must be paid on time to keep this Policy in force. This section explains how and when premiums are to be paid.

PAYMENTS
Premiums are payable at the Company's Home Office or to any of the Company's authorized agents. The first premium is due on the Effective Date. Each subsequent premium is due on the first day following the interval for which the preceding premium was paid or within the Grace period specified in the Policy.

RIGHT TO CHANGE PREMIUM
The Company reserves the right to change all premiums applicable to this Policy on any premium due date by giving written notice to the Insured and Policyholder at least 60 days in advance of the date premium is to be changed.

RENEWAL/TERMINATION

This Policy is a renewable plan and may be renewed at the option of the Company. The Policyholder or the Company may terminate this Policy on any date on or after the first Policy Anniversary Date by giving at least 30 days written notice to the other party.

CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be given within 30 days after a covered loss starts or as soon as reasonably possible. Notice must be given by or on behalf of the claimant to the Company or its administrator at 7909 Parklane Road, Suite 200, Columbia, South Carolina 29223 or to any of the Company's authorized agents. Notice must include the name of the Insured Person, the Policy number and nature of the loss.

CLAIM FORM
When the Company or its administrator receives the notice of claim, forms will be sent to the Insured Person for filing proof of loss. If these forms are not provided within 15 days, the Insured Person will meet the proof of loss requirements by giving the Company or its administrator a signed written statement of the nature and extent of the loss within the limit stated in the proof of loss provision.

PROOF OF LOSS
Written proof of loss must be given to the Company or its administrator within 90 days after the date of such loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the Insured Person is legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Any benefit payable under this Policy will be paid not more than 60 days after the Company or its administrator receives proper written proof of such loss.

PAYMENT OF CLAIMS
All benefits will be payable to the Insured, unless the Company or its administrator receives written assignment of benefits to a provider of covered services. Any accrued benefits unpaid at the Insured's death will be paid to the estate of the Insured.

FACILITY OF PAYMENT
If any benefit is payable to an Insured's estate or to a minor or person not otherwise competent to give a valid release, the Company or its administrator may pay such benefit, up to an amount not exceeding $1,000, to any relative by blood or by marriage who the Company or its administrator considered to be entitled to the benefit. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company to the extent of such payment.

GENERAL PROVISIONS

ENTIRE CONTRACT
This Policy, the Policyholder's Application, along with the Insured's individual application, if any, and any endorsements and/or riders, is the entire contract between the Policyholder and the Company. All statements made by the Insured or the Policyholder, in the absence of fraud will be deemed representations and not warranties. No such statement will void the insurance or reduce the benefits under this Policy or be used in defense of a claim unless it is contained in a written application and a copy is provided to the Insured Person or beneficiary. No change in this Policy will be valid until approved by one of our officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

GRACE PERIOD
The Company will allow a period of 31 days after the premium due date for payment of each premium after the first premium payment. This Policy is in force during this period.

TIME LIMIT ON CERTAIN DEFENSES
Misstatements in the application: After two years from the date the Insured Person becomes covered under this Policy, no misstatements, except fraudulent misstatements of a material fact made by the Insured in the Insured's application will be used to void coverage or to deny a claim for a loss that begins after the two year period.

CONFORMITY WITH STATE STATUTES
Any provision of this Policy that is in conflict with the laws of the state where the Policyholder is located on its effective date is amended to conform to minimum requirements.

INDIVIDUAL CERTIFICATES
The Company will issue a Certificate for each Insured which will describe:

1. the benefits to which an Insured Person is entitled under this Policy;
2. to whom such benefits are payable;
3. the limitations and requirements of this Policy; and
4. where this Policy may be inspected.

Nothing in the Certificate will change, modify or invalidate any of the terms and conditions of this Policy.

POLICY INSPECTION
This Policy may be inspected by any Insured Person any time during the regular business hours of the Policyholder.

POLICY AMENDMENTS
Subject to the laws of the state in which this Policy is issued, it may be changed, at any time by written amendment agreed to by the Company and the Policyholder. Premium rates may be changed according to the Premiums provision. Any amendments to this Policy will apply to all Insured Persons whether insured prior to or after the effective date of the amendment.

LEGAL ACTIONS
No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No such action may be brought after three years from the time written proof of loss is required.

MISSTATEMENT OF AGE
If the age of any Insured Person is incorrectly stated, we will make a fair adjustment of the premiums, benefits or both. The adjustment will be based on the premiums and benefits that would have been payable had we know the correct information.

CLERICAL ERROR
Clerical errors or delays in keeping records for this Policy:

a. will not deny insurance which would otherwise have been granted;
b. will not continue insurance which otherwise would have ceased; and
c. will call for an adjustment of premium benefits to correct the error.

WORKERS' COMPENSATION & WORKMEN'S COMPENSATION NOT AFFECTED
This Policy is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance or Workmen's Compensation Insurance.

PHYSICAL EXAMINATION AND AUTOPSY
The Company, at Our own expense, will have the right and opportunity to examine any Insured Person for whom a claim is pending when and as often as it may reasonably be required during the pendency of a claim. The Company, at Our own expense, will have the right to make an autopsy in case of death, unless it is forbidden by law.

ADDING INSUREDS
Additional Insureds may be added to the original group under this Policy, from time to time, according to the terms of this Policy.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Privacy Promise

We will keep your medical information private. We will also give you this notice about our privacy practices, our legal duties and your rights concerning your medical information. We will follow the privacy practices that we describe in this notice while it is in effect. This notice took effect April 14, 2003, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. We reserve the right to make these changes effective for all medical information that we keep, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice accordingly and send the new notice to you prior to the effective date of the change.

You may request a copy of this notice at any time or view a copy on our Web site at www.CompanionLife.com.

Uses and Disclosures of Medical Information

Treatment, Payment, Health Care Operations

We may use and disclose your medical information for purposes of treatment, payment and health care operations. For example:

Treatment: We may disclose your medical information to a physician or other health care professional so they can treat you.

Payment: We may use and/or disclose your medical information for these and other related activities:

- To pay claims from physicians, hospitals and other health care professionals for covered services you received.
- To determine your eligibility for benefits.
- To coordinate those benefits.
- To determine medical necessity.
- To obtain premiums.
- To issue explanations of benefits to the named insured.

We may also disclose your medical information to a health care professional or entity that is bound by the federal Privacy Rules so they can obtain payment or engage in payment activities.

Health Care Operations: We may use and/or disclose your medical information in the normal course of our health care operations. This includes:

- Determining our risk and premiums for your health plan.
- Quality assessment and improvement activities.
- Reviewing the qualifications of health care professionals; evaluating practitioner and provider performance; conducting training programs; and accreditation, certification, licensing and credentialing activities.
- Medical review, legal services and auditing, including fraud and abuse detection and compliance programs.
- Business planning and development.
- Business management and general administrative activities, including management activities relating to privacy, customer service, internal grievances and creating de-identified information or a limited data set.

We may disclose your medical information to another entity, which has a relationship with you and is also bound by the federal Privacy Rules, for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

Your Authorization

You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time. However, this will not affect any uses and disclosures we made while your authorization was in effect. Without your written authorization, we will not use or disclose your medical information for any reason except those described in this notice.

Your Family and Friends

We may disclose your medical information to a family member, friend or other person to the extent necessary for them to assist with your health care, or with payment for your health care. We may also use or disclose your medical information to notify (or help notify, including identifying and locating) a family member, a personal representative or other person responsible for your care of your location, general condition or death.

Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we will disclose your medical information based on our professional judgment of what would be in your best interest.

Your Employer or Organization Sponsoring Your Group Health Plan

We may disclose summary information about you to your employer or plan sponsor for two reasons. One is to get premium bids for the health insurance coverage offered through your group health plan. The second is to decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses or types of claims members of your group health plan have filed. The summary information will not include demographic information about the people in the group health plan,

but your employer or plan sponsor may be able to identify you or others from the summary information.

Underwriting
We may receive your medical information for underwriting, premium rating or other activities necessary to create, renew or replace a contract of health insurance or health benefits. We will not use or further disclose this medical information for any other purpose (except as required by law) unless the contract of health insurance or health benefits is placed with us, in which case we will use and disclose your medical information as described in this notice.

Disaster Relief
We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit
We may use or disclose your medical information as authorized by law for the following purposes that are in the public interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.
- To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person.
- To coroners, medical examiners and funeral directors.
- To organ procurement organizations.
- To avert a serious threat to health or safety.
- In connection with certain research activities.
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities.
- To correctional institutions regarding inmates.
- As authorized by state workers' compensation laws.

Health-Related Services
We may use your medical information to contact you about health-related benefits and services, or about treatment alternatives. We may disclose your medical information to a business associate to assist us in these activities.

Marketing
We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication, or to provide you with promotional gifts of nominal value.

Individual Rights

Access

You have the right to in spect or get copies of your m edical information, with some exceptions. You may request th at we provide copies in a format other than photo copies. We will use the format you request unless it is not practical to do so. To get y our medical information, you must make a request in writing. If you request copies, we will charge you $0.5 0 for each page and for staff time to copy your m edical information. We also will charge for posta ge if you want us to mail the co pies to you. If you req uest another format, we will ch arge a cost-bas ed fee for providing your medical information in that format. Contact us using the inform ation listed at the end of this notice for a full explanation of our fees.

Disclosure Accounting

You have the righ t to request, in writing, to recei ve a list of instances in which we (or ou r business associates) disclosed your m edical information for purposes other than treatm ent, payment and health care operati ons, or as authorized by you, or for certain other activities allowed by law, on or after April 14, 2003. We will provide you with the date on which we made each disclosure, the name of the person or en tity to which we disclos ed your medical information, a description of the m edical information we disclosed and the reason for the disclosure. If you request this accou nting more than once in a 12-m onth period, we m ay charge you a reasonable, cost-based fee for each additional request. Cont act us using the inform ation listed at the end of this notice for a full explanation of our fees.

Restriction

You have the right to request, in writing, that we place addition al restrictions on our use or disclosure of your m edical information. W e are not required to agr ee to these additional restrictions, but if we do, we will abide by our agreement (except in an em ergency). Any agreement to additional restrictions m ust be in writing signed by a person authorized to m ake such an agreement for us. We will not be bound unless our agreement is in writing.

Confidential Communications

You have the right to request, in writing, that we comm unicate with you about your m edical information by other m eans, or to other locations. You must state that you could be in danger if we do not communicate to you in confidence. We must accommodate your requ est if it is reasonable, if it specifies the other means or location, and if it permits us to con tinue to collect premiums and pay claims under your health plan. This includes sending explanations of benefits to the named insu red of your health p lan. We will not be bou nd to your confidential communications request unless our agreement is in writing.

Even though you requested that we comm unicate with you about your health care in confidence, an explanation of benefits issued to the named insured for health care that the named insured (or others covered by the health plan) received might contain sufficient inform ation, such as deductible and out-of-pocket amounts, to reveal that you obtained health care for which we paid.

Amendment
You have the right to request, in writing, that we amend your medical information. Your request must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available, or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation.

You may respond with a statement of disagreement that we will add to the information you wanted to amend. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including people you name, and to include the changes in any future disclosures of that information.

Electronic Notice
If you are viewing this notice on our Web site or by electronic mail (e-mail), you may request this notice in written form by using the information listed at the end of this notice.

Questions and Complaints

If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your privacy rights, you may tell us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information
Companion Life
Bruce Honeycutt, Privacy Officer
I-20 @ Alpine Road (AX-E01)
Columbia, SC 29219

(803) 264-7258 (telephone)
(803) 264-7257 (fax)