Voluntary Accidental Death & Dismemberment Summary Plan Description

For Employees of
Regions Financial Corporation

TO OUR EMPLOYEES:

Accidents happen suddenly…you don't expect them…there's no way to anticipate them…and they don't always happen to somebody else.

Each year more than 97,000 American lives are lost due to accidents - over 22,000 lives lost yearly due to homicides. Accidents remain the fifth leading cause of death among Americans of all ages. And, for workers under age 38 - just when the financial responsibilities for establishing and maintaining a comfortable standard of living are at their peak - accidents are the leading cause of death.*

As safety-conscious as you are, on the job, on the road, at home, on vacation - you can't always control all of the circumstances that could place you in physical danger. And you can't evaluate in advance the extent to which your family's security could be affected by the financial consequences of an accident.

But, through the economical plan outlined on the following pages, you can be prepared to deal with some of the financial consequences of an accident by providing for your family's future security easily and quickly.

The Plan is described in greater detail in the following pages of this booklet. We hope all eligible employees will elect to participate as it is felt that this insurance will be a valuable supplement to your existing coverage.

*Accident Facts, 1997 Edition (National Safety Council, Chicago, IL)

OUTSTANDING FEATURES OF THE PLAN

1. Amounts of $50,000; $100,000; $250,000; or $500,000 may be selected.

2. Coverage available for spouse and dependent children.

3. Coverage provided without regard to previous health history.

4. Provides broad twenty-four (24) hour protection, year round.

5. Pays in addition to any other insurance You may now carry.

6. Economical cost (substantially less than comparable coverage available on an individual basis).

ELIGIBILITY

You are eligible to enroll in this plan if You are an active full-time employee of Regions Financial Corporation and work a minimum of 30 hours per week. Under Dependent Coverage, You may insure Your family members as follows:

Your spouse and Your dependent child(ren) under 19 years of age or until age 25 if they are full-time students, dependent on You for support and maintenance.

Coverage will be extended for any dependent child who, upon reaching the stated maximum age, is mentally or physically incapable of self-sustaining support and who is dependent upon You for support and maintenance.

NOTE: No eligible individual may be covered more than once under this Plan. If You are covered as an employee, You cannot be covered as a Spouse or Dependent Child of another employee.

COVERAGE

The plan offers worldwide protection, twenty-four (24) hours a day, three hundred sixty five (365) days a year, against any type of accident in the course of business or pleasure, including accidents on or off the job, in or away from the home, commuting, traveling by train, airplane, automobile, or other public and private conveyances. It also covers accidents while riding as a passenger in any licensed civilian aircraft or in any aircraft operated by the which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

The benefits provided are payable in addition to any other insurance which may be in effect at the time of the accident.

EXCLUSIONS

The plan does not cover any loss resulting from suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury; war or any act of war, whether declared or undeclared; involvement in any type of active military service; illness (excluding Travel Assistance Plan) or disease or infection; pregnancy, including childbirth, but not including complications thereof; participation in the commission or attempted commission of any felony or assault; flying as a pilot or crew member of any aircraft; any aircraft being used for aerial photography, test or experimental purposes; any aircraft that requires a special permit or waiver even if granted; any aircraft owned or controlled by, or under lease to the Policyholder, an Insured, or a member of a Covered Person's family or household; any aircraft which is operated by the Policyholder, or one of its employees including members of an employee's family or household; any conveyance used in a race or speed test or being used for tests or experimental purposes; being under the influence of any controlled substance unless prescribed by a physician; or being intoxicated.

THE BENEFITS

COVERAGES

ACCIDENTAL DEATH BENEFIT

If a Covered Person dies as a result of an Injury, We will pay the Principal Sum. The death must occur within 365 days of the Injury.

ACCIDENTAL DISMEMBERMENT OR COVERED LOSS OF USE BENEFIT

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

The benefit amounts are based on the Covered Person's Principal Sum.

Loss of	**Benefit**
1. Both hands or both feet	100% of Principal Sum
2. One hand and one foot	100% of Principal Sum
3. One hand or one foot plus the loss of sight of one eye	100% of Principal Sum
4. Sight of both eyes	100% of Principal Sum
5. Speech and Hearing	100% of Principal Sum
6. Speech or Hearing	50% of Principal Sum
7. One Hand; one foot; or sight of one eye	50% of Principal Sum
8. Thumb and index finger of the same hand	25% of Principal Sum

Loss of Use of	
1. Four limbs	100% of Principal Sum
2. Three limbs	100% of Principal Sum
3. Two Limbs	75% of Principal Sum
4. One limb	50% of Principal Sum

For purposes of this benefit:

1. Loss shall mean:
   - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint ;
   - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
   - **c.** Total and permanent loss of sight;
   - **d.** Total and permanent loss of speech;
   - **e.** Total and permanent loss of hearing.
2. Loss of Use shall mean total paralysis of a limb or limbs which is determined by Our competent medical authority to be permanent, complete and irreversible.

If more than one Loss arises out of the same accident, We will pay only one benefit. This will be the largest one. If a Covered Person can recover benefits under both the **Accidental Dismemberment and Covered Loss of Use Benefit** and the **Accidental Death Benefit** as a result of the same accident, the most We will pay is the Principal Sum.

EXPOSURE AND DISAPPEARANCE COVERAGE

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

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

COMA BENEFIT

If a Covered Person sustains an Injury within 365 of a covered accident, and such Injury causes the Covered Person to be in a Coma for at least 31 consecutive days, We will pay a Monthly Coma Benefit.

The Monthly Coma Benefit is equal to 2% of the Covered Person's Principal Sum, and shall be paid each month the Covered Person remains in a Coma following the initial 31 day period. The Monthly Coma Benefit will end on the earliest of the following:

1. the Covered Person is no longer in a Coma, which directly resulted from the Injury;
2. the Covered Person received a Monthly Coma Benefit for 50 months.

Coma shall be determined by Our competent medical authority. In no event shall the total amount paid for all benefits resulting from the Covered Loss exceed the Covered Person's Principal Sum.

YOU CHOOSE THE AMOUNT AND THE PLAN

Plan I Employee Only:

You may purchase one of the following amounts of Principal Sum: $50,000; $100,000; $250,000; or $500,000.

Coverage for Your Dependents:

You may prefer to become insured by one of the Dependent Coverage options under which Your spouse and Your dependent children automatically become insured.

Plan II

You will be insured for the amount You select. Your spouse and dependent children will be insured as follows:

Spouse:

(1) 50% of Your Principal Sum Benefit, if there are no dependent children at the time of loss.

(2) 40% of Your Principal Sum Benefit, if there are dependent children at the time of loss.

Dependent Children:

(1) 20% of Your Principal Sum Benefit, if Your spouse is not insured at the time of loss.

(2) 15% of Your Principal Sum Benefit, if Your spouse is insured at the time of loss.

The maximum amount for any one child is $50,000.

Amounts and Cost

Premiums will be paid by means of payroll deductions from Your salary

	Employee Only	**Employee and Family Plan**
Principal Sum	**Plan I**	**Plan II**
$ 50,000	$ .50	$ .80
100,000	1.00	1.60
250,000	2.50	4.00
500,000	5.00	8.00

NOTE: If You are age 70 or older at the time of a covered accident, any plan benefits, other than covered family members' **Accidental Death Benefit** and **Accidental Dismemberment and Covered Loss of Use Benefit**, that are based on Your Selected Benefit Amount will be computed on the Reduced Benefit Schedule as follows:

If You are age 70 or older at the time You sustain injuries in a covered accident, Your Plan benefit reduces to 65% of selected Principal Sum.

ADDITIONAL BENEFITS

ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN

If the Insured selects a Plan covering his or her eligible Dependent Child(ren), and a Covered Dependent Child suffers an Injury resulting in a Covered Loss, which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, We will pay the Insured an additional benefit which will be equal to the lesser of the benefit amount provided by the **Accidental Dismemberment and Covered Loss of Use Benefit** or $50,000.

AFTER SCHOOL CARE BENEFIT

If an Insured selects a Plan covering his or her Dependents and the Insured or his or her Covered Spouse suffers an Injury resulting in a Covered Loss which is payable under the **Accidental Death Benefit**, We will reimburse the charges actually incurred for the after school care to the individual who incurs the expense for each Covered Dependent Child, who is ten (10) years old or less, up to a maximum of the lesser of:

1. 10% of the applicable Principal Sum paid under the **Accidental Death Benefit** per year; or
2. $10,000 per year.

The after school care provider may not be a relative or family member and proof, acceptable to Us must be provided to establish eligibility for this benefit.

If the Insured and his or her Covered Spouse both die as a result of the same Covered Injury, and We pay an Accidental Death Benefit on both Covered Persons, only the Insured's Principal Sum will be used to calculate the amount applicable under this benefit.

This benefit will be paid each year for four (4) consecutive years if the Covered Dependent Child is under age ten (10) at the time of each payment.

COBRA BENEFIT

If an Insured selects a Plan covering his or her Dependents and the Insured suffers an Injury resulting in a Covered Loss, which is payable under the **Accidental Death Benefit**, and the Insured is covered under a medical plan sponsored by the Policyholder, We will pay an additional benefit to continue medical insurance for the Insured's surviving family members for a period of one (1) year. The amount payable under this benefit will be the lesser of:

1. 10% of the Insured's Principal Sum;
2. $10,000; or
3. The actual cost to the surviving family members to continue medical coverage for one (1) year under the plan sponsored by the Policyholder.

COMMON DISASTER BENEFIT

If an Insured selects a Plan covering his or her Dependents and the Insured and his or her Covered Spouse are both eligible for **Accidental Death Benefits** as a result of Covered Injuries suffered in the same Accident and within 90 days of such Accident, the Principal Sum that would have been payable because of the Covered Spouse's Accidental Death will be increased to equal that payable for the loss of the Insured, provided:

1. the Insured and Covered Spouse are survived by one or more Covered Dependent Child(ren); and
2. the combined benefits of the Insured and the Covered Spouse are not more than $1,500,000.

CONTINUATION OF INSURANCE BENEFIT

If an Insured selects a Plan covering his or her Dependents, and the Insured suffers an Injury resulting in a Covered Loss, which is payable under the **Accidental Death Benefit**, all Coverages under this Policy which were in force on the date of the loss, with respect to Covered Persons other than the Insured, will be continued automatically for 2 years after the date of the loss at no additional cost.

ADDITIONAL BENEFITS continued

DAY CARE BENEFIT

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

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

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

8. the actual cost of the child care;
9. 10% of the Principal Sum of the Covered Person who suffered the Covered Loss; or
10. $10,000.

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

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

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

An Accredited Child Care Facility means:

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

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

FELONIOUS ASSAULT BENEFIT

If an Insured suffers an Injury resulting in a Covered Loss, which is payable under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit** as a result of a violent or criminal act committed by someone other than the Insured, a Fellow Employee or a member of his or her Family or Household, We will pay an additional benefit equal to 15% of the Insured's Principal Sum to a maximum of $100,000, provided:

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

For purposes of this benefit:

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

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

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

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

ADDITIONAL BENEFITS continued

HIGHER EDUCATION BENEFIT

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

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

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

The Higher Education Benefit will be equal to 10% of the Insured's Principal Sum, to a maximum of $10,000. This amount will be paid annually for four (4) consecutive years if the Covered Dependent Child continues his or her education. Before this benefit is paid each year, the Covered Dependent Child must present written proof, acceptable to Us, that he or she is attending an institution of higher learning on a full-time basis.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

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

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

The amount We will pay will be equal to:

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

Benefits will not be payable unless:

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

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

REHABILITATION BENEFIT

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

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

Rehabilitation Training means a treatment program that:

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

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

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

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

SEAT BELT/AIR BAG BENEFIT

If a Covered Person suffers an Injury resulting in a Covered Loss, which is payable under the **Accidental Death Benefit**, and the Injury which caused the accidental death directly resulted from an automobile Accident, We will pay an additional benefit, which equals 10% of the applicable Principal Sum up to a maximum of $25,000, provided that the Covered Person was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and

2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the Injury.

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

1. in the official law enforcement report of the Accident, through certification by the investigating officers; or

2. by other reasonable proof, acceptable to Us.

An additional benefit equal to 10% of the Covered Person's Principal Sum to a maximum of $25,000, will be paid if the Covered Person was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the Covered Person's seat belt or lap and shoulder restraint was properly fastened at the time of the Accident. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the Accident, through certification by the investigating officers or by other reasonable proof, acceptable to Us.

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

1. under the influence of alcohol;

a. A driver will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the Accident occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle.

b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,

2. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.

SPOUSE RETRAINING BENEFIT

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

1. the purpose of the training program is to obtain an independent source of support and maintenance;

2. the actual cost is incurred within thirty (30) months from the death of the Insured; and

3. the professional or trade training program is licensed by the state.

The maximum amount payable under this benefit will be the actual cost incurred or $10,000.

THERAPEUTIC COUNSELING BENEFIT

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

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

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

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

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

The maximum amount payable under this benefit is $2,500 for any one Covered Accident.

TRAVEL ASSISTANCE PLAN

This **Travel Assistance Plan** will apply to the following Covered Persons when they are traveling 100 miles or more from their Principal Residence: the Insured and his or her Spouse and/or Child(ren), if covered under this Policy. The transportation and/or services provided under this **Travel Assistance Plan** must be pre-authorized by Us. Under this Policy, the **Travel Assistance Plan** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation

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

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

The amount We will pay for this benefit is unlimited.

Medical Repatriation

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

The amount We will pay for this benefit is unlimited.

Non-Medical Repatriation

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

The amount We will pay for this benefit is unlimited.

Return of Remains

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

Visit to Hospital

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

TRAVEL ASSISTANCE PLAN continued

Return of Child

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

Return of Companion

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

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide the Travel Assistance Plan if the Coverage is excluded under Section VII – General Exclusions of the Policy (except for the exclusion of illness), or if:

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

- **TRAVEL ASSISTANCE DEFINITIONS**

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

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

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

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

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

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

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

TRAVEL ASSISTANCE PLAN continued

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Right of Recovery

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

Reservation of Rights

We reserve the right to suspend, curtail or limit Our coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit Us to provide services 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 this **Travel Assistance Plan,** is solely covered under this **Travel Assistance Plan,** and in no way supercedes or modifies the other Coverages provided under this Policy.

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

TO APPLY FOR COVERAGE

1. Select the amount which best fits Your needs from the **Benefits and Cost Table**.
2. Complete the on-line application form when you enroll during your initial enrollment period when you are hired or during the open enrollment period for benefits. If you have a change in life status (marriage, divorce, birth of child, etc.) during the year, you may make a written request for change in your coverage.

   Be sure to indicate the amount and the plan desired (Employee Only or Employee and Family).
3. If you are actively at work, your insurance will take effect:
   - **a.** on the first of the month on or following your date of hire when you enroll during your initial enrollment period;
   - **b.** on January 1 if you enroll during the open enrollment period; or,
   - **c.** if are making a change in your coverage during the year due to a change in life status, the changes in your coverage will take place on the qualifying event date.

An active employee may terminate insurance by withdrawing his or her authority for the payroll deduction. Such termination must be made in writing over the employee's signature and will be effective the first day of the month following withdrawal.

Everyone must complete the enrollment form. If You decide not to participate, please check the appropriate box at the bottom of the form and sign and return the form as instructed.

BENEFICIARY

Your Loss of Life benefit will be payable to the beneficiary or beneficiaries You designate for the Group Life Insurance policy. If You did not name a beneficiary for the Policyholder's Group Life Insurance policy, 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: 1) Your spouse; 2) Your children; 3) Your parents; 4) Your brothers and sisters; or, 5) Your estate.

If You select a plan covering Your dependents, You will be the beneficiary of Your spouse and children unless otherwise designated.

TERMINATION OF INSURANCE

The insurance coverage will be continued until the end of the month in which Your employment terminates.
Insurance will terminate in the event of retirement or termination of employment for any reason, or the Insurance Company or the Policyholder declines to renew the Master Policy.

CONVERSION PRIVILEGE

An Insured is entitled to convert his or her Coverage to an Individual Accidental Death or Dismemberment (IAD) policy or to a Family AD&D (FAD) policy if the Insured selected a Plan covering his or her Dependents if eligibility ends for any reason other than age or termination of the Group Insurance Policy. The Insured must make a written application for the IAD or FAD policy within sixty (60) days of the cessation of insurance under the Group Accident Policy. To request a Conversion Application Form, the Insured must call 1-800-834-1959. The Insured does not have to show proof of good health.

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

1. the Principal Sum for the IAD or FAD policy will be the lesser of the Insured's Principal Sum under the Group Accident Policy or $500,000;
2. the premium for the IAD or FAD policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. any IAD or FAD policy issued will take effect on the termination date of the Insured's insurance under the Group Accident Policy; and
4. when an IAD or FAD policy becomes effective, the relationship between the Insured and Us will be governed by that policy, including all terms and conditions, and benefits and termination dates.

This policy provides ACCIDENT Insurance only.
It does NOT provide basic hospital, basic medical or major medical insurance.

IMPORTANT NOTICE:
THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

PLEASE RETAIN THIS BOOKLET WITH YOUR VALUABLE PAPERS,.
IT WILL CONSTITUTE YOUR CERTIFICATE OF INSURANCE IF YOU ENROLL.

CERTIFICATE OF INSURANCE on the following pages.

This booklet-summary plan description provides You with an easy-to-understand summary of the Voluntary Accident Insurance Plan as well as Your actual Certificate of Insurance and Summary Plan Description.

If any conflict should arise between the content of this booklet-summary plan description and the Master Policy or if any point is not covered herein, the terms of the Master Policy will govern in all cases.

Certificate of Insurance

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

Having issued **Accident Policy** Number GTU 4279171 to cover the eligible individuals of:

Regions Financial Corporation

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

IMPORTANT NOTICE

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

TABLE OF CONTENTS

SECTION I – ELIGIBILITY AND EFFECTIVE DATES

CERTIFICATEHOLDER:

Class I: All **Active** full-time employees of the **Policyholder** working a minimum of 30 hours per week.

Note: If **You** suffer an **Injury** resulting in a **Covered Loss** and **You** are covered under more than one class, **We** will pay only one benefit, the largest benefit.

ELIGIBILITY OF INSURED'S DEPENDENTS:

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

EFFECTIVE DATE OF INSURANCE FOR THE INSURED:

A. For eligible individuals hired prior to January 1, 2008:
January 1, 2008, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

B. For eligible individuals hired on or after January 1, 2008:
on the first day of the month on or next following the employee's date of hire provided the completed enrollment material is received by the **Policyholder**.

SECTION II – SCHEDULE

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

BENEFITS:	**Classes Covered**
Accidental Death Benefit	All

Principal Sum:

Class I: **You** may purchase one of the following amounts of **Principal Sum:** $50,000; $100,000; $250,000; or $500,000.

The **Principal Sum** for **Your Covered Dependents** will be a percentage of **Your Principal Sum**, as follows:

Plan Selected	**% Spouse**	**% Child(ren)**
Spouse only:	50%	0
Dependent Child(ren) only:	0	20%
Spouse and **Dependent Child(ren):**	40%	15%

Maximum of $50,000 **Principal Sum** for **Dependent Child(ren)**.

At age 70, for the **Covered Employee** only, the **Principal Sum** will be reduced based on the **Covered Employee's** previous **Principal Sum** per the following schedule:

Age at Date of Loss	**Percent of Principal Sum**
70 & Over	65%

Accidental Dismemberment and Covered Loss of Use Benefit	All

Principal Sum:

Same as above.

Coma Benefit	All

ADDITIONAL BENEFITS:	**Classes Covered**
Additional Dismemberment Benefit for Children	All
After School Care Benefit	All
COBRA Benefit	All
Common Disaster Benefit	All
Continuation of Insurance Benefit	All
Day Care Benefit	All
Felonious Assault Benefit	All
Higher Education Benefit	All
Home Alteration and Vehicle Modification Benefit	All
Rehabilitation Benefit	All
Seat Belt/Air Bag Benefit	All
Spouse Retraining Benefit	All
Therapeutic Counseling Benefit	All
Travel Assistance Plan	All

SECTION III – DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

Dependent Child(ren), if used in the **Policy,** means **Your** unmarried **Child(ren)** who rely on **You** for more than 50% of their support, and are either: 1) less than nineteen (19) years of age; 2) less than twenty-five (25) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap. The **Dependent Child(ren)** will only be **Covered Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.

Injury means a bodily **Injury** .

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

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

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

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

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

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

acrobatic or stunt flying
hanggliding
racing
test or experimental purpose
flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted

Spouse, if used in the **Policy,** means **Your** legally married **Spouse**. **Your Spouse** will only be a **Covered Spouse** if a **Plan** covering **Your Spouse** is selected.

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

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

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

SECTION IV – COVERAGES

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

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

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

Hazard Limitations:

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

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

1. medical certificate; and

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

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

Hazard Exclusions:

Coverage is not provided:

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

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

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

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

All aircraft owned or leased by the **Policyholder**

provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least 1,000 hours as a pilot of which at least 500 hours were logged in this or the same class of aircraft.

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

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

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

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

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

EXPOSURE AND DISAPPEARANCE COVERAGE

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

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

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

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

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

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

ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

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

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

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

Covered Loss of Use of	
1. Four **Limbs**	**Principal Sum**
2. Three **Limbs**	75% of **Principal Sum**
3. Two **Limbs**	66 2/3% of **Principal Sum**
4. One **Limb**	50% of **Principal Sum**

For purposes of this benefit:

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

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

COMA BENEFIT

If a **Covered Person** suffers an **Injury** within 365 days of a **Covered Accident**, and such **Injury** causes the **Covered Person** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay a **Coma Benefit**.

The **Coma Benefit** will be equal to 2% of the **Covered Person's Principal Sum** and will be paid each month the **Covered Person** remains in a **Coma** following the initial thirty-one (31) day period. The **Coma Benefit** will end on the earliest of the following:

1. when the **Covered Person** is no longer in a **Coma** which directly resulted from the **Injury**;
2. when the **Covered Person** has received a **Coma Benefit** for 50 months.

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

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

SECTION VI – ADDITIONAL BENEFITS

ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN

If **You** selected a **Plan** covering **Your** eligible **Dependent Child(ren),** and a **Covered Dependent Child** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment Benefit, We** will pay **You** an additional benefit which will be equal to the benefit amount provided by the **Accidental Dismemberment Benefit.**

AFTER SCHOOL CARE BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Spouse** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, **We** will reimburse the charges actually incurred for the after school care to the individual who incurs the expense for each **Covered Dependent Child**, who is ten (10) years old or less, up to a maximum of the lesser of::

1. 10% of the applicable **Principal Sum** paid under the **Accidental Death Benefit** per year; or
2. $10,000 per year.

The after school care provider may not be a relative or family member and proof, acceptable to **Us** must be provided to establish eligibility for this benefit.

If **You** and **Your Covered Spouse** both die as a result of the same **Covered Injury**, and **We** pay an **Accidental Death Benefit** on both **Covered Persons**, only **Your Principal Sum** will be used to calculate the amount applicable under this benefit.

This benefit will be paid each year for four (4) consecutive years if the **Covered Dependent Child** is under age ten (10) at the time of each payment.

COBRA BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, and **You** are covered under a medical plan sponsored by the **Policyholder**, **We** will pay an additional benefit to continue medical insurance for **Your** surviving family members for a period of one (1) year. The amount payable under this benefit will be the lesser of:

1. 10% of **Your Principal Sum**;
2. $10,000; or
3. the actual cost to **Your** surviving family members to continue medical coverage for one (1) year under the plan sponsored by the **Policyholder**.

COMMON DISASTER BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** and **Your Covered Spouse** are both eligible for **Accidental Death Benefits** as a result of **Covered Injuries** suffered in the same **Accident** and within ninety (90) days of such **Accident**, the **Principal Sum** that would have been payable because of **Your Covered Spouse's Accidental Death** will be increased to equal that payable for **Your** loss, provided:

1. **You** and **Your Covered Spouse** are survived by one or more **Covered Dependent Child(ren)**; and
2. the combined benefits of **You** and **Your Covered Spouse** are not more than $1,500,000.

CONTINUATION OF INSURANCE BENEFIT

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

DAY CARE BENEFIT

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

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

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

1. the actual cost of the child care;
2. 10% of the **Covered Person's Principal Sum** who suffered the **Covered Loss;** or
3. $10,000.

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

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

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

An **Accredited Child Care Facility** means:

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

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

FELONIOUS ASSAULT BENEFIT

If **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit** or **Accidental Dismemberment and Covered Loss of Use Benefit** as a result of a violent or criminal act committed by someone other than **You**, a **Fellow Employee** or a member of **Your Family** or **Household**, **We** will pay an additional benefit equal to 15% of **Your Principal Sum** to a maximum of $100,000, provided:

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

For purposes of this benefit:

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

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

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

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

HIGHER EDUCATION BENEFIT

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

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

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

The **Higher Education** will be equal to 10% of **Your Principal Sum**, to a maximum of $10,000. This amount will be paid annually for four (4) consecutive years if **Your Covered Dependent Child** continues his or her education. Before this benefit is paid each year, **Your Covered Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

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

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

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

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

Benefits will not be payable unless:

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

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

REHABILITATION BENEFIT

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

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

Rehabilitation Training means a treatment program that:

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

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

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

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

SEAT BELT/AIR BAG BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, **We** will pay to the beneficiary an additional benefit, which equals 10% of the applicable **Principal Sum** up to a maximum of $25,000, provided that the **Covered Person** was:

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

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

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

An additional benefit equal to 10% of the **Covered Person's Principal Sum** to a maximum of $25,000, will be paid if the **Covered Person** was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the **Covered Person's** seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.

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

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

SPOUSE RETRAINING BENEFIT

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

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

The maximum amount payment under this benefit will be the actual cost incurred or $10,000.

THERAPEUTIC COUNSELING BENEFIT

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

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

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

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

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

The maximum amount payable under this benefit is $2,500.00 for any one **Covered Accident**.

TRAVEL ASSISTANCE PLAN

This **Travel Assistance Plan** will apply to the following **Covered Persons** when they are traveling 100 miles or more from their **Principal Residence**: the **Insured** and his or her **Spouse** and/or **Child(ren),** if covered under the **Policy.** The transportation and/or services provided under this **Travel Assistance Plan** must be pre-authorized by **Us**. Under the **Policy,** the **Travel Assistance Plan** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation

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

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

Medical Repatriation

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

Non-Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable which is also subject to the prior recommendation of the attending physician. The upgrade will be subject to **Our** sole discretion.

Return of Remains

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

Visit to Hospital

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

Return of Child

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

Return of Companion

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

- **TRAVEL ASSISTANCE EXCLUSIONS**

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

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

- **TRAVEL ASSISTANCE DEFINITIONS**

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

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

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

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

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

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

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

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Right of Recovery

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

Reservation of Rights

We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services 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 the **Travel Assistance Plan,** is solely covered under the **Travel Assistance Plan,** and in no way supercedes or modifies the other benefits provided under the **Policy**.

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

SECTION VII – GENERAL EXCLUSIONS

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

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness (excluding Travel Assistance Plan) or disease or infection;
5. pregnancy, including childbirth, but not including complications thereof;
6. participation in the commission or attempted commission of any felony or an assault;
7. being intoxicated.
   a. A **Covered Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Covered Person's** intoxication.
8. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
9. travel or flight in any aircraft except to the extent stated in the **Coverage** Section.

SECTION VIII – GENERAL LIMITATIONS

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

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

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

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

SECTION IX - TERMINATION OF INSURANCE

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

1. the **Policy** is terminated;
2. **You** cease to be eligible for insurance;
3. **You** fail to pay the required premium, if **You** are so required;
4. **You** retire.

If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written Policy, **Your** insurance under the **Policy** will continue, provided the required premiums are paid. This extension of **Coverage** is subject to all of the termination provisions of the **Policy** with the exception of number 2. above.

Your **Covered Dependent's** Insurance. Insurance terminates on the earliest of:

1. the date **Your** insurance terminates;
2. the first premium due date after **Your Covered Dependent** no longer qualifies as a **Covered Person**;
3. for **Your Covered Spouse**, the date **Your Covered Spouse** reaches age 70.

Conversion Privilege

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

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

1. The **Principal Sum** for the **IAD** or **FAD** policy will be the lesser of **Your Principal Sum** under the Group **Accident Policy** or $500,000;
2. The premium for the **IAD** or **FAD** policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. Any **IAD** or **FAD** policy issued will take effect on the termination date of **Your** insurance under the Group **Accident Policy**; and
4. When an **IAD** or **FAD** policy becomes effective, the relationship between **You** and **Us** will be governed by that policy, including all terms and conditions, including benefits and termination dates.

SECTION X - HOW TO FILE A CLAIM

A. Notice. You or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. The notice must name the **Covered Person** who sustained the **Injury**, **You**, and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1-866-841-4771. The notice must be sent to the Claims Department, Zurich American Insurance Company, P.O. Box 307010, Jamaica, NY 11430-7010, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

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

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

SECTION XI - PAYMENT OF CLAIMS

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

B. Who We Will Pay.

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

a. **Your** legally married **Spouse**;

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

c. **Your** parents;

d. **Your** brothers and sisters;

e. **Your** estate.

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

3. All Other Claims. Benefits are to be paid to the **Covered Person**. The **Covered Person** may direct in writing that all, or part of the **Accident Medical Expense Benefit**, if applicable, will be paid directly to the party who furnished the service. The **Covered Person** may change the direction at any time up to the filing of the proof of **Covered Loss**.

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

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

SECTION XII - GENERAL POLICY CONDITIONS

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

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

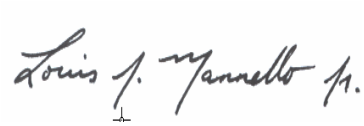
C. Clerical Error. A clerical error or omission will not increase or continue **Your Coverage** which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

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

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

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

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



Louis J. Mannello, Jr.
President
Zurich American Insurance Company

David Bowers
Corporate Secretary
Zurich American Insurance Com

NON-PARTICIPATING

Regions Financial Corporation
GTU 4279171
Effective: January 1, 2008

Version: January 2008

U-VA-102-A (AL) (09/06)

ERISA
SUMMARY PLAN DESCRIPTION
INFORMATION

The plan described in this certificate, together with the following information, constitutes the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 as amended.

The Plan Sponsor's name is: Regions Financial Corporation

The Plan Sponsor is: Regions Financial Corporation
1900 Fifth Avenue North
Birmingham, AL 35203
(205) 944-1300

The Employer Identification Number (EIN) is: 63-0589368

The Plan Number is: 501

The Plan Administrator is: Regions Financial Corporation
1900 Fifth Avenue North
Birmingham, AL 35203
(205) 944-1300

The Claims Fiduciary is Zurich American Insurance Company.

The agent for the service of legal process is: Regions Financial Corporation
1900 Fifth Avenue North
Birmingham, AL 35203
(205) 944-1300

The benefits of the Plan are provided under Policy No. GTU 4279171, underwritten by Zurich American Insurance Company located in Schaumburg, IL with administrative offices in Jamaica, NY.

The plan is financed through contributions made by: the Employee.

Plan Year Ends: December 31.

For a description of the eligibility requirements of the plan, the amount and type of benefits available, the circumstances under which benefits under the plan are not available or may terminate, please refer to this certificate.

Plan Termination: The right is reserved in the plan for the Plan Administrator to terminate, suspend, withdraw, or amend the plan in whole or in part at any time, subject to the applicable provisions of the Policy.

CLAIM PROCEDURES

Filing a Claim for Benefits

When you are reasonably sure that you are eligible to receive benefits under this plan, you may request a claim form from the Plan Administrator. All claims submitted to the Insurer must be on forms provided by the Insurer (unless forms are not currently available), in which case you, your beneficiary or a legally authorized representative may simply supply the appropriate party with a written statement outlining proof and extent of loss. Complete the claim form according to directions and return the claim form to the Plan Administrator.

From the date your notice of claim is returned, the insurance company has 90 days in which to review the claim to determine whether or not benefits are payable in accordance with the terms and provisions of the Group Policy. Under special circumstances the insurance company may require an extension of the 90 day period in which case you will receive written notice from the insurance company, prior to the end of the initial 90 days, informing you of the need for an extension. This extension period allows the insurance company an additional 90 days to review your claim. During this period the insurance company may require a medical examination, at its own expense, or additional information in order to make a determination on your claim. If additional information is required you will receive a request, in writing, specifying the nature of the information needed and an explanation as to why it is needed. If a medical examination is necessary, you will be given the time of appointment and the doctor's name and location. It is important to keep any appointments made since rescheduling exams will delay the claim process.

If you are not notified of the claim status within 90 days and you have not been notified that the extension period has been applied, you may request a review of your claim by following the procedure outlined under "Claim Review Procedure."

Once your claim has been approved, you will receive the appropriate benefit from the insurance company.

What if your Benefits are denied?

If your claim for benefits is denied in whole or in part, you will receive written notice of such denial within the 90 day period stated above (or 180 days if the extension period is required).

Each written notice of denial shall set forth:

1. the specific reason(s) for the denial of the claim;
2. a specific reference to the provision(s) of the Group Policy upon which the denial is based;
3. a description of any additional information or material needed and why; and
4. notice of your rights to have the denial reviewed by the insurance company, and to bring suit under ERISA if the review also results in an adverse benefit determination..

Claim Review Procedure

If you receive a written notice of denial, you or your duly authorized representative may request a review of the claim by giving written notice to the insurance company. This request for a review must be made to the insurance company within 60 days of the receipt of denial by the insurance company. If such request is not made within 60 days you will be deemed to have waived your right to a review.

Once the insurance company receives a request for a review, a prompt review of the claim must take place. You or your authorized representative have the right to review documents that might have a bearing on the claim including the documents which establish and control the plan, and to submit issues and comments that you feel might affect the outcome of the review.

Upon completion of a full and complete review, the insurance company will notify you in writing of the results, citing plan provisions that control the decision. The insurance company has 60 days to notify you of its decision unless special circumstances require an extension of time. If an extension is required, the insurance company shall notify you of the need for an extension before the end of the initial 60-day period for completing the review procedure. This means that the insurance company will have an additional 60 days to notify you of the decision on your denied claim.

What If Your Benefits Continue To Be Denied?

If your claim for benefits continues to be denied, you will receive written notice of such continued denial within the 60-day period stated above (or 120 days if an extension period is required).

The written notice of denial shall set forth:

1. the specific reason(s) for the continued denial on review of the claim;
2. reference to the specific plan provision(s) on which the denial on review is based;
3. a statement regarding your right to access and receive copies of relevant documents, records and other information upon request, without charge; and
4. notice of your rights to pursue other voluntary dispute resolution alternatives, if available, and to bring suit under ERISA.

STATEMENT OF ERISA RIGHTS

Your Rights under ERISA: Your Employer intends to comply fully with the Employee Retirement Income Security Act of 1974 and the regulations under the Act as it understands them. The Act provides for certain rights and protections for each participant of the Plan. As a participant in this Group Insurance Plan you may:

1. Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.