National Guardian® Life Insurance Company

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191 • Phone 888-274-8050

GROUP SUPPLEMENTAL BENEFIT CERTIFICATE

Underwritten by: National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: Equipoint Partners LLC
400 Chisholm Place, Suite 304
Plano, TX 75075
1-866-972-2368

Group Policy No. **P3045** ("the policy"), has been issued to **Equipoint Partners, LLC** which we will refer to as "the Policyholder". We will refer to National Guardian Life Insurance Company as "we", "us", or "our".

The policy was delivered in Texas and will be governed by the laws thereof and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments.

This Certificate of Insurance is evidence of the Insured's insurance under the policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the policy. The policy is on file with the Policyholder and may be examined at any reasonable time. Only one of our executive officers can authorize a change to the policy.

This Certificate of Insurance replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the policy.

The Secretary and President of National Guardian Life Insurance Company witness this Certificate:

Secretary

President

THIS CERTIFICATE OF INSURANCE PROVIDES LIMITED SUPPLEMENTAL ACCIDENT & SICKNESS COVERAGE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT. READ THIS CERTIFICATE CAREFULLY.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

RIGHT TO EXAMINE CERTIFICATE. This Certificate of Insurance can be returned for any reason within 30 days after it is received by the Insured. The certificate should be returned by mail or in person to the Administrator. Any premium paid will be refunded and the certificate will be treated as if it were never issued.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

1. ELIGIBILITY: All employees working at least 40 hours per week who have completed 30 days of employment and who, on the effective date of their coverage under the policy, are covered under the Policyholder's Other Plan.

   Dependent Coverage: _X_ Yes ___ No

2. COVERAGE YEAR: Begins on each January 1st and continues for the next 12 consecutive months, and ends on December 31st of the same year.

3. COVERAGE AND BENEFIT AMOUNTS:

   Supplemental Medical Expense Benefit

Inpatient and Outpatient Benefits	
Maximum Benefit (per Coverage Year)	$7,350/person $14,700/family
Deductible (per Coverage Year)	$0/per person
Outpatient Doctor Visit Co-payment	N/A
Percentage of Covered Expenses Policy Pays	100%
Benefit limitation:	
Maximum amount of Covered Expenses eligible for payment (per Coverage Year)	$7,350/person $14,700/family

   *If, in any one Coverage Year, there are 4 or more persons covered under the policy due to the same Insured and at least 2 of them have satisfied their individual deductible amount, then no deductible amount will be required for any other person covered under the policy due to the same Insured during that same Coverage Year.

   Other Benefits

   None

4. INDIVIDUAL EFFECTIVE DATE: the following shall apply to eligible employees of the Policyholder and their eligible dependents.

   The first of the month following the date all payroll deductions equaling one month's premium have been made.

GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event that causes Injury to one or more Covered Persons.

"Affordable Care Act" means the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)), as amended.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985.

“Co-payment” means a specified amount that a Covered Person is responsible for paying, each time the Covered Expense is incurred, before benefits are payable under the policy. When a covered expense is subject to a Co-payment, a deductible will not be applied to that same expense.

“Coverage Year” means the period of time described in the Schedule of Benefits.

“Covered Expenses” are the unpaid portions of charges for medical care, treatment and services as described in the section titled Description of Benefits.

"Covered Person" means any eligible person for whom coverage is in effect under the policy.

"Deductible" means the amount of Covered Expenses that must be paid by a Covered Person before benefits are payable under the policy. This amount applies separately to each Covered Person and must be satisfied each Coverage Year, unless otherwise shown in the Schedule of Benefits.

"Doctor" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.

"Eligible Dependents" are those dependents of an Insured who are extended coverage under the Policyholder’s Other Plan. Eligible Dependents of an Insured may be covered under the policy only while they are covered under the Policyholder’s Other Plan.

"Hospital" means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility, or a facility for treatment of mental disorders.

"Injury" means bodily harm to a Covered Person:

a) caused by an Accident; and
b) not caused, or contributed to, by Sickness; and
c) that results in loss covered by the policy.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

"Inpatient" means a Covered Person who has been formally admitted to a Hospital for purposes of receiving inpatient Hospital services for no less than 23 hours.

"Insured" means an employee for whom coverage is in effect under the policy.

"Outpatient" means a Covered Person who incurs medical expenses while other than an Inpatient at a Hospital.

“Policyholder’s Other Plan” means a written health benefit plan that:

a) is provided on a fully-insured basis or otherwise;
b) provides major medical or comprehensive health coverage for charges, which are incurred by persons who are covered thereunder, for medical care, treatment and services;
c) has a deductible and/or coinsurance provision that requires a person to pay covered charges out-of pocket; and
d) is compliant with the applicable requirements of the federal Affordable Care Act.

"Sickness" means illness or disease of a Covered Person that is not due to Injury, and which results in loss covered by the policy.

INDIVIDUAL EFFECTIVE DATES

Insured: Non-Contributory - Coverage for an eligible person will become effective on the latest of:

a) the Policy Effective Date if the person is eligible and premium has been received on or before that date; or

b) the first day of the month after the person becomes eligible if the person becomes eligible after the Policy Effective Date and premium is received within 31 days after the date the person becomes eligible; or

c) as shown in the Schedule of Benefits.

Insured: Contributory - Coverage for an eligible person will become effective on the latest of:

a) the Policy Effective Date if the person is eligible and such person's enrollment and premium have been received on or before that date; or

b) the first day of the month after the person becomes eligible if the person becomes eligible after the Policy Effective Date, and such person's enrollment and premium are received within 31 days after the date the person becomes eligible; or

c) as shown in the Schedule of Benefits.

An eligible person may enroll or be enrolled only within 31 days after becoming eligible or acquiring a new dependent, or during an open enrollment period, unless otherwise indicated by the policy. Open enrollment period means a pre-determined term during which any eligible person who previously did not enroll or was not enrolled for coverage under the policy may enroll or be enrolled for coverage.

Dependents - Dependent insurance will become effective on the latest of:

a) the Insured's effective date if the dependent is eligible as of the Insured's effective date and the Insured enrolls and pays premium for the dependent on or before that date; or

b) if a dependent is not eligible as of the Insured’s effective date, such dependent’s coverage will be effective once the dependent becomes eligible, provided payroll deductions equaling one month’s premium have been made and enrollment has been completed for such coverage; or

c) as provided in the Schedule of Benefits.

In no case will coverage for Eligible Dependents take effect before the Insured's.

Newborn Dependent Coverage: A child of the Insured who is an Eligible Dependent and who is born while the policy is in force is provided coverage. The child is covered from the moment of birth until the 31st day of age. A notice of birth and the additional premium, if any, must be submitted to the Administrator within 31 days of the birth in order to continue coverage beyond the initial 31-day period.

Adopted Dependent Coverage: A minor child who is an Eligible Dependent and for whom the Insured or spouse is a party in a suit seeking adoption while the policy is in force will be provided coverage from the date the suit for adoption is instituted provided the Insured enrolls the child and pays any required premium within 31 days after the date the adoption becomes final. However, coverage will begin at the moment of birth if the suit for adoption, enrollment for coverage and payment of premium occur within 31 days after the child’s birth. Coverage for such child will continue unless the suit for adoption is dismissed or denied.

INDIVIDUAL TERMINATION DATES

Insured - Coverage for an Insured will end on the earliest of:

a) the date the Insured is no longer eligible unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid; or

b) any premium due date, if full payment for the Insured's coverage is not made within 31 days following the premium due date; or

c) the date that the policy terminates.

Dependents - Coverage for dependents will end on the earlier of:

a) the Insured's termination date; or

b) any premium due date, if full payment for the dependent's coverage is not made within 31 days following the premium due date; or

c) the date the dependent is no longer an Eligible Dependent unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid.

In no case will coverage end later than the Insured's.
Termination will not affect a claim for benefits for Covered Expenses incurred while the person is covered by the policy.

EXTENSION OF BENEFITS

If coverage under the policy ends while the Covered Person is totally disabled due to Injury or Sickness, we will pay benefits for Covered Expenses incurred after the date coverage under the policy ends provided they meet the following requirements:

a) the Covered Expense must be incurred due to the same Injury or Sickness causing the Covered Person to be totally disabled on the date coverage ends; and
b) the Covered Expense must occur within 90 days after the date the Covered Person's coverage under the policy ends; and
c) coverage must not have ended as a result of the Covered Person's or, in the case of a dependent child, the child's parents' voluntary termination of the coverage.

This extension of benefits terminates at the end of the 90-day period specified above.

As used in this provision, the phrase "totally disabled" means:

a) with respect to a Covered Person who would otherwise be employed, the complete inability to perform all of the substantial and material duties of such person's occupation; and
b) with respect to a Covered Person who is not otherwise gainfully employed, confinement as an Inpatient in a Hospital.

DESCRIPTION OF BENEFITS

We will pay the applicable benefit percentage for the Covered Expenses described below, up to the applicable Coverage Year maximum. Benefits will be paid, after satisfaction of any applicable Deductible or Co-payment amount and subject to any applicable benefit limitation, for Covered Expenses that are incurred while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be for covered Injury or Sickness. Deductible and Co-payment amounts, benefit percentages, maximums, and limitations are shown in the SCHEDULE OF BENEFITS.

Covered Expenses are the unpaid portions of charges for medical care, treatment and services that are eligible for reimbursement under and deemed allowable by the Policyholder’s Other Plan, and which are not excluded from coverage under the policy.

CONTINUATION OF COVERAGE

The following continuation provision applies only when a Covered Person has elected to continue his or her coverage under the Policyholder's Other Plan through a similar continuation privilege. If the Covered Person has not elected to continue coverage under the Policyholder's Other Plan, then this Continuation of Coverage provision is not available.

Coverage for Covered Expenses incurred as a result of Injury or Sickness, may be continued, under certain circumstances. Medical information regarding the condition of a person's health is not required for this continued coverage. If a Covered Person exercises this option, it will be in lieu of any continuation rights granted under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Eligibility:
Insured - Insureds may elect to continue coverage for themselves and their covered dependents. Coverage may be continued for 18 months if one of the following events occurs:

a) an Insured's employment is terminated for any reason other than gross misconduct; or
b) a reduction in an Insured's hours results in the loss of such coverage.

Disabled Insured - Insureds who are determined to be disabled under the Social Security Act within 60 days of the date they become eligible for continuation under this provision, may continue coverage for themselves and their covered dependents for up to 29 months.
Dependents - A covered dependent may elect to continue coverage for a period of 36 months if one of the following events occurs:

a) the death of the Insured;
b) the divorce of the Insured and dependent spouse;
c) the Insured becomes entitled to Medicare benefits;
d) a dependent child is no longer a dependent child for the purposes of the plan.

Coverage:
If a Covered Person exercises this option, coverage will be identical in scope to the coverage provided in the policy.

Premiums:
The Covered Person will pay premiums directly to the Policyholder with the option of paying in monthly installments. The premiums will not exceed 102 percent of the applicable premium for such period.

Notice Requirements:
The Policyholder must notify the Administrator in writing within 31 days after the date:

a) the Insured dies; or
b) the Insured's employment is terminated or the Insured's hours are reduced; or
c) the Insured becomes entitled to Medicare benefits.

Each covered dependent who wishes to continue coverage must notify the Administrator in writing within 60 days after the date:

a) of divorce from the Insured; or
b) a dependent child is no longer a dependent child for the purposes of the plan.

Upon our receipt of any such notice, we must give written notice of the right to continue coverage to the Covered Person(s) within 14 days.

Covered Persons who wish to continue coverage must notify the Administrator in writing within 60 days after the date they receive notice of their right to continue coverage.

Termination:
Covered Persons who exercise this option will not have their coverage interrupted or canceled or otherwise terminated until the date on which:

a) they fail to make a premium payment in the time required to make that payment; or
b) they fail to remain covered under the Policyholder's Other Plan; or
c) they become covered under another group health plan, without limitation as to any pre-existing condition that affects coverage; or
d) they become entitled to Medicare benefits; or
e) the required period for continued coverage ends; or
f) the policy is terminated.

EXCLUSIONS

No benefits will be paid for loss caused by or resulting from:

a) intentionally self-inflicted injuries, suicide or any attempt thereat while sane or insane;

b) declared or undeclared war or any act thereof;

c) the Covered Person's commission of a felony;

d) work-related Injury or Sickness; and

e) the Covered Person's voluntary participation in a riot, civil commotion or disobedience, or unlawful assembly.

In addition to the above exclusions, no benefits will be paid for:

a) Co-payment amounts charged under the Policyholder's Other Plan;

b) non-prescription drug or Outpatient prescription drug charges;

c) charges that are not eligible for reimbursement under the Policyholder's Other Plan;

d) charges for medical care, treatment and services, or portions thereof, that are in excess of what is deemed allowable by the Policyholder's Other Plan; and

e) charges for medical care, treatment and services that are incurred at a provider that is not included in the provider network of the Policyholder's Other Plan, unless otherwise covered under the Policyholder's Other Plan.

PREMIUMS

Premiums are shown in the Schedule of Benefits. Premium must be paid to the Administrator on or before the premium due date and not more than 31 days after the effective date of an eligible person's coverage. A person's coverage will not be affected by the Policyholder's failure, due to clerical error, to remit premiums to the Administrator on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first Policy Anniversary Date, with 60 days' advance notice in writing to the Policyholder. We may also change premiums on the date coinciding with the date:

a) the Policyholder's Other Plan is modified in a manner that changes the risk factors bearing on our benefit obligation under policy; or

b) Federal or State law is modified in a manner that directly affects our benefit obligation under the policy.

Grace Period: The Policyholder has a 31-day grace period after each ensuing premium due date once the first premium has been paid. During such grace period, coverage under the policy will continue in force. If the premium is not paid by the end of the grace period, coverage will end. The Policyholder will remain liable to us for any unpaid premium including any premium due for that part of the grace period through which claims were paid.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 30 days after a loss occurs, or as soon as reasonably possible. The notice must be given to the Administrator. Claims should be sent to:

National Guardian Life Insurance Company
c/o TPA Name and Address

Claim Forms: When the Administrator receives notice of claim that does not contain all necessary information or is not on an appropriate claim form, forms for filing proof of loss will be sent to the claimant along with a request for any missing information. If these forms are not sent within 15 days after receiving notice of claim, the claimant will meet the proof of loss requirements if the Administrator is given, within 90 days, written proof of the nature and extent of the loss. The notice should include the Insured's name, the Policyholder and the policy number.

Proof of Loss: Written proof of loss must be given to the Administrator within 90 days after the loss begins. Since this is Supplemental Accident and Sickness Coverage, a claim must be filed with the Policyholder's Other Plan first. The Policyholder's Other Plan will process the claim and issue an explanation of benefits (EOB). That EOB is the required proof of loss for a claimant to submit a claim under the policy. The claimant should forward the EOB along with a copy of the appropriate claim form to the Administrator. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within 1 year after it is due, unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid not more than 60 days after the Administrator's receipt of proper written proof of such loss.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any benefits due and unpaid at the Insured's death will be paid to the Insured's estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the claim is pending.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 3 years from the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

Incontestability: The validity of the policy will not be contested except for nonpayment of premiums. The validity of a Participating Organization's coverage under the policy will not be contested except for non-payment of premium. No statement made by the Policyholder or any Covered Person, except a fraudulent one, will be used to contest a claim under the policy. We may only contest coverage if the misstatement is made in a written instrument signed by the Policyholder or the Covered Person and a copy is given to the Policyholder or Covered Person.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Termination of Policy: The Policyholder may terminate the policy at any time on or after the first anniversary of the policy's effective date, by sending us written notice. The policy will be terminated on the date that we receive the notice or later if specified in the notice.

We may terminate the policy:

a) at any time on or after the first anniversary of its effective date, by sending the Policyholder at least 31 days' prior written notice to its most recent address in our records; or
b) on the date coinciding with the date the Policyholder's Other Plan is modified in a manner that changes the risk factors bearing on our benefit obligation under policy; or
c) on the date coinciding with the date Federal or State law is modified in a manner that directly affects our benefit obligation under the policy; or
d) on the date coinciding with the date the Policyholder's Other Plan is terminated.

We will return pro-rata the unearned portion of the premiums, if any, that were paid. Termination will not affect a claim for benefits for Covered Expenses incurred while the policy was in force.