

MASTER POLICY

Conifer Insurance Company located in Troy, Michigan, having issued a Master Policy Number MPMS-0000001 (hereinafter referred to as the "Master Policy") to the Motion Matters Initiative, an association located at 675 S Green Valley Parkway #1032, Henderson, Nevada 89502, hereby certifies that the individual members of the above-referenced association, listed by Certificate of Insurance and attached and made a part hereto as named in the application for coverage under the "Master Policy", is insured under the "Master Policy" subject to all the terms, conditions, coverages, coverage limits, exclusions and endorsements of the "Master Policy" including any amendments thereto.

The coverages described in the "Master Policy" and the limits of liability as shown in the attached Certificate of Insurance shall be payable subject to the limits of liability shown therein and subject to all the terms, coverage exclusions, policy provisions and conditions of the "Master Policy".

There is no coverage under this Master Policy for any individual member of the Motion Matters Initiative, unless such coverage is specifically listed in the attached Certificate of Insurance.

The "Master Policy" constitutes the one and only agreement under which payments are made on behalf of any individual member of the Motion Matters Initiative. This "Master Policy" alone constitutes the only agreement under which payments are made.

This document is issued as a notice of insurance only and does not constitute a legal contract of insurance.

The original "Master Policy" may be inspected at the office of the Motion Matters Initiative, an association located in Henderson, Nevada.

Various provisions in this policy of insurance restrict and limit coverage. **Read this policy in its entirety carefully to determine your rights and the Company's duties as well as what is covered and excluded in this insurance policy.**

The words "you", "your" and "insured" used throughout this policy refer to the Named Insured shown in the Certificate of Insurance. The words "we", "us" and "our" refer to Conifer Insurance Company providing this insurance.

Any other word or phrase that appears in quotation marks throughout this policy has special meaning and if not defined above are defined in the Definitions section of this policy.

This insurance covers loss only for the specifically named perils in the Coverage section of this policy. Any cause of loss that is neither specifically named within the Coverage section of this policy nor attached by endorsement, is excluded from coverage under this insurance regardless of whether or not such cause of loss is included in the Exclusions section of this policy.

Policyholder	Motion Matters Initiative			
Policy Number	MPMS-0000001			
Policyholder Mailing Address	675 S Green Valley Parkway #1032, Henderson, Nevada 89502			
Policy Period	Effective Date	11/1/2023	Expiration Date	9/30/2025
	12:01 A.M. Standard Time at Mailing Address of the Policyholder			
State of Delivery	Nevada			

The Policy takes effect at 12:01 A.M. of the Policy Period Effective Date shown above. It will remain in effect for the duration of the Policy Period shown above if the premium is paid according to the agreed terms. The Policy terminates at 12:01 A.M., on the Policy Period Expiration Date.

The Policy is governed by the laws of Nevada.

When the initial policy is received, if you are not satisfied with the policy, you may return it to us within ten (10) days prior to the initial coverage effective date. We will then cancel this policy and refund the premium in full.

THIS IS AN ACCIDENT ONLY POLICY. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED BY FEDERAL LAW.

LIMITED BENEFITS: THE POLICY PAYS BENEFITS FOR SPECIFIC LOSSES DURING THE COVERED ACTIVITIES SHOWN IN THE SCHEDULE OF BENEFITS ONLY. PLEASE READ THE POLICY CAREFULLY.

NOTICE

THIS NOTICE IS TO ADVISE THE POLICYHOLDER THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING THIS POLICY, YOU MAY CONTACT support@verticalinsure.com

THE DEPARTMENT OF INSURANCE SHOULD BE CONTACTED ONLY AFTER DISCUSSIONS WITH THE INSURANCE COMPANY OR ITS REPRESENTATIVES HAVE FAILED TO PRODUCE A SATISFACTORY RESOLUTION TO THE PROBLEM.

A. THINGS YOU SHOULD KNOW

When does my coverage begin and end?

You are covered under this policy on the Effective Date shown on the Schedule of Benefits after:

- You have applied for coverage;
- We have approved Your application; and
- You have paid the required premium.

Your coverage ends on the Expiration Date shown on the Schedule of Benefits, subject to any prior cancellation by you or us.

Are there any significant and unusual exclusions or limitations?

These are all set out full in the policy wording, but please note the following:

- The insurance excludes any known pre-existing medical conditions.
- There is an exclusion for losses arising from war or terrorism and from firearms and explosives.

How do I file a claim?

Online: <https://verticalinsure.com/claims/gap-medical>

B. SCHEDULE OF BENEFITS

INDIVIDUAL ACCIDENT INSURANCE SCHEDULE OF BENEFITS

Policyholder Name	<i>Policyholder name</i>	Policy Number	<i>Policy number</i>
Policyholder Mailing Address	<i>Mailing address</i>	Policyholder Email Address	<i>email</i>
Policy Period	Effective Date		Expiration Date
	12:01 A.M. Standard Time at the Mailing Address of the Policyholder		
Policy Premium	Policy Premium		

The Policy Premium is based on the rates currently in force and on the limits of the insurance and benefits in effect.

COVERED PERSON AND COVERED ACTIVITIES

Policyholder Covered Activity	Spectator at Your Child's Covered Activity
Your Child's Name	<i>childs name</i>
Your Child's Age at Policy Effective Date	<i>age</i>
Your Child's Covered Activity	<i>sport</i>
Organization Sponsoring Your Childs' Covered Activity	<i>organization</i>

Subject to all of the terms and conditions of the policy, benefits described in the policy are payable when **you** or **your child** suffers a **loss** as a result of an **accident** during a **covered activity**.

BENEFITS, LIMIT OF INSURANCE AND DEDUCTIBLE

Benefits	Limit of Insurance
YOUR CHILD - ACCIDENT MEDICAL EXPENSE REIMBURSEMENT FULL EXCESS	\$5,000

Regardless of the number of **accidents** or covered **injuries** that occur during the **policy period**, **our** total limit of insurance for the **policy period** for all coverage and benefits provided under this policy shall not exceed the amounts shown above. For more details on the Limit of Insurance and Deductible, please see section F. LIMITS OF INSURANCE AND DEDUCTIBLES

C. POLICY DEFINITIONS

Some words or phrases in the policy have been defined below. Defined words or phrases are printed in **bold** and have the following meanings, unless a different meaning is described in a particular coverage.

You, Your	The Policyholder as shown on the Schedule of Benefits.
We, Us, Our	Conifer Insurance Company
Child	Your dependent child, including a natural child, stepchild, or a child placed with you for adoption or foster care, who is under the age of 26 at the inception of the policy, shown on the Schedule of Benefits and for which a premium has been paid.
Accident	A sudden, unforeseeable event during the policy period causing injury to you or your child .
Actual Cost(s)	The standard costs and fees a physician would charge, regardless of whether that customer or patient has insurance coverage.
Chiropractic Treatment	Treatment by a licensed chiropractor operating within the scope of his or her license, consisting of the manipulation and/or adjustment of the spine, skeletal articulations, and adjacent tissue.
Covered Activity	The activity(ies) shown on the Schedule of Benefits that takes place during the policy period and within the coverage territory .
Coverage Territory	The United States, its territories and possessions.
Injury(ies)	Bodily harm caused by an accident that occurs during the policy period . All injuries sustained in one accident , including all related conditions and recurring symptoms of the injuries will be considered one injury.
Loss	An eligible benefit occurring during the policy period .
Limit of Insurance	The most we will pay under this policy for the coverage and benefits as shown on the Schedule of Benefits.
Medical Expenses	The following expenses you incur for the treatment that you or your child receives to treat a covered injury : <ol style="list-style-type: none"> 1. Medical services (including charges for anesthetics, x-ray examinations or treatments, and laboratory tests) and supplies, prescription drugs, and therapeutic services ordered or prescribed by a physician; 2. Hospital or ambulatory medical-surgical center services; and 3. Local ambulance services to and/or from a hospital.
Medically Necessary	Medically Necessary means <ol style="list-style-type: none"> 1. A treatment, service or supply that is require to treat an injury; 2. Prescribed or ordered by a physician or furnished by a hospital; 3. Performed in the least costly setting required by the condition; 4. Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. <p>The purchasing or renting of air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered medically necessary.</p>

	The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it medically necessary or covered by this Policy.
Other Valid and Collectible Insurance	<p>Any reimbursement for or recovery of any element of Medical Expenses incurred available from any other source whatsoever, except gifts and donations, but including without limitation:</p> <ol style="list-style-type: none"> 1. Any individual, group, blanket, or franchise policy of Accident, disability or health insurance. 2. Any arrangement of benefits for members of a group, whether insured or uninsured. 3. Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations. 4. Any amount payable for hospital, medical or other health services for the accidental bodily injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy. 5. Any amount payable for services or injuries or diseases related to your job to the extent that you actually received benefits under a Workers' Compensation Law. If you enters into a settlement to give up your rights to recover future medical expenses that would have been payable except for that settlement. 6. Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to you after you become disabled while insured hereunder. 7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.
Physician	A person who is a qualified practitioner of medicine. Such person must be acting within the scope of his/her license and under the laws in the state in which he or she practices and must be providing only those medical services which are within the scope of his/her license or certificate. Such person cannot be you nor a family member.
Policy Period(s)	The period specified on the Schedule of Benefits, subject to any cancellation prior to the scheduled expiration.
Pre-existing Condition(s)	<p>An injury, illness, disease or other condition that in the 24-month period before this coverage became effective:</p> <ol style="list-style-type: none"> 1. First manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinary or prudent person to seek diagnosis, care or treatment; or 2. Required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or 3. Was treated by a physician or treatment had been recommended by a physician.
Treatment(s)	Any medically necessary medical care administered and medications requiring a prescription that are prescribed by a physician , or under a physician's direct supervision, in treating your or your child's injury.

D. BENEFIT PROVISIONS

Upon **your** payment of the premium when due, and in reliance of the statements **you** made in the application, **we** will provide coverage as specifically described in this policy for **you** and for **your child** listed on the Schedule of Benefits. Unless stated to the contrary, all benefits are subject to all the terms, conditions, exclusions and limitations as stated herein and as shown on the Schedule of Benefits.

ACCIDENT MEDICAL EXPENSES REIMBURSEMENT BENEFIT: We will reimburse **you**, up to the **limit of insurance**, the **actual cost(s)** of **medical expenses** incurred by **you** for the **treatment you** or **your child** receives for an **injury** caused by an **accident** while participating in a **covered activity**. The **treatment** must be administered or prescribed within ninety (90) days of **your** or **your child's injury** to be eligible for reimbursement.

CHIROPRACTIC CARE SUBLIMIT: Notwithstanding the Limit of Insurance shown on the Schedule of Benefits, the maximum amount we will pay for **chiropractic treatment** is \$500 per policy period. This sublimit is part of, and not in addition to, the Accident Medical Expense Reimbursement Benefit limit shown on the Schedule of Benefits.

FULL EXCESS PROVISION Insurance provided by this policy for this benefit shall be excess of all **other valid and collectible insurance**. If at the time of the **injury** there is **other valid and collectible insurance** or indemnity in place, **we** shall be liable only for the excess of the amount of loss, over the amount of such other insurance or indemnity. Recovery of losses from other parties does not result in a refund of premium paid.

E. WHAT WE DO NOT COVER

1. This policy does not cover:
 - i. Any **loss** if **you** have not complied with all conditions related to coverage set forth in this policy;
 - ii. Any **pre-existing condition**;
 - iii. **Treatment** rendered outside the **coverage territory**;
 - iv. Experimental or elective **treatment**, routine physical examinations, hearing aids, eye glasses, contacts or hearing aids.
2. **We** will not reimburse **you** for any **injury** caused by, arising out of or related to, directly or indirectly, any of the following:
 - i. An **accident** or **injury** that occurred before **you** and **your child** are covered by this policy;
 - ii. An **accident** or **injury** that occurred outside the **coverage territory**;
 - iii. Sickness, disease, or mental, nervous or psychological disorder or infirmity, including any medical or surgical treatment thereof;
 - iv. Intentionally self-inflicted **injury**, suicide or attempted, while sane or insane;
 - v. Participation in any kind of sporting or leisure activity for compensation or profit, including coaching or officiating;
 - vi. Participation in a **covered activity** against medical advice;
 - vii. **You** or **your child** traveling to or from the **covered activity**, including traveling to and from practice or special events related to the **covered activity**;
 - viii. Being under the influence of alcohol or narcotics, unless administered on the advice of a **physician**, or performance-enhancing drugs;
 - ix. **Injury** occurring after the **policy period**;
 - x. **Injury** from any person's use of firearms or explosives;
 - xi. War, invasion, acts of foreign enemies, hostilities between nations (whether declared or undeclared), or civil war; or an act of terrorism.

F. LIMITS OF INSURANCE

1. LIMITS OF INSURANCE: Regardless of the number of **accidents** or covered **injuries** that occur during the **policy period**, **our** total limit of insurance for the **policy period** for all coverage and benefits provided under this policy shall not exceed the amount shown on the Schedule of Benefits.

G. CLAIM PROVISIONS

1. **NOTICE OF CLAIM:** Notice of a claim must be reported to **us** within thirty (30) days after the **accident** occurs or the **treatment** is provided, whichever is later, or as soon thereafter as is reasonably possible. **You** or someone on **your** behalf may give notice. The notice should provide sufficient information to identify **you**.

2. **CLAIM FORM:** When notice of claim is received by **us**, the forms for filing proof of loss will be furnished. If such forms are not furnished within fifteen (15) days after receipt of **your** notice, the proof of loss requirements can be met by **you** sending **us** a written statement of what happened. This statement must be received within the time given for filing proof of loss.

3. **PROOF OF LOSS:** Written proof of loss must be furnished to **us** within ninety (90) days after the date of such loss.

The following documentation must be submitted with the claim form:

- i. Receipts from the providers of service, stating the amount paid and listing the diagnosis and treatment;
- ii. Provide a copy of the final disposition of **your** claim under **your** primary medical or health insurance or other primary accident insurance.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of **your** legal capacity, later than one year from the time proof is otherwise required.

4. **PAYMENT OF LOSS:** Once **you** have provided written proof of loss, **we** will pay any benefits due to **you**, within thirty (30) days from the date of **our** receipt of all required information. This payment will include the effect of the **deductible** calculations and deducted non-coverable items, if applicable and any **limits of insurance**. **We** cannot preauthorize or guarantee coverage of a claim. Please keep in mind, **you** are financially responsible to the health service provider for payment of all **treatment**.

5. **EXAMINATION:** **We** have the right to have a **physician** of **our** choice at **our** own expense examine the person for who the claim is being made under this policy.

6. **COOPERATION:** Failure of a claimant to cooperate with **us** in the administration of a claim may result in the delay or termination of benefits. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

H. GENERAL CONDITIONS

1. **RENEWABILITY:** This policy is short term, single premium and non-renewable at expiration. To obtain another policy, you must submit another application for a quote.
2. **CONCEALMENT, MISREPRESENTATION OR FRAUD:** We are not obligated to provide coverage under this policy if **you** at any time intentionally conceal, misrepresent or exaggerate a material fact concerning:
 - i. This policy;
 - ii. **You or your child;** or
 - iii. A claim under this policy.

The falsity of any statement **you** make shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by **us**.

3. **CONFORMITY TO STATE STATUTES:** Any policy provision which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery, is amended to conform to the minimum requirements of such statute.

4. **ENTIRE POLICY:** This policy, the Schedule of Benefits, the application and any endorsements contain all the agreements between **you** and **us**. The terms may not be changed or waived except by an endorsement issued by **us** and made a part of this policy.

5. **ELECTRONIC DELIVERY:** It is agreed that, unless otherwise notified by **you**, all written documents and communications regarding this policy, its endorsements, and any notices may be delivered to **you** by electronic mail using the email address associated with **your** policyholder account, except documents required to be delivered by another method. It is further agreed that it is **your** responsibility to keep **your** contact details, including email, telephone and postal address, current and correct.

6. **LEGAL ACTIONS:** No one may bring a legal action against **us** until there has been full compliance with all the terms of this policy. No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. **You** will have three (3) years from the time written proof of loss is required to be furnished to take legal action against **us** with respect to recovery of a claim under this policy.

7. **OUR RIGHT TO RECOVER PAYMENT:** We reserve the right to recover from **you** any benefits **we** have paid for **injuries** received for a covered accident under:
 1. Workers' Compensation or similar statutory remedies available under law; or
 2. Any employer's liability insurance.

8. **TIME LIMIT ON CERTAIN DEFENSES:** After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by you in the application shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of such 3 year period. No claim for loss incurred commencing after 3 years from the date of issue of this policy shall be reduced or denied on the ground that a physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

THIS ENDORSEMENT EFFECTIVE: 12:01 A.M., June 1, 2024

POLICY: MPMS-0000001

ISSUED TO: Motion Matters Initiative

BY: Conifer Insurance Company

Effective June 1, 2024, the Expiration Date is amended to read 9/30/2025.

In consideration of the above, there is no additional premium.

THIS ENDORSEMENT EFFECTIVE: 12:01 A.M., November 20, 2025

This endorsement modifies insurance provided under the following:

MASTER POLICY NUMBER: MPMS-0000001

CHIROPRACTIC CARE SUBLIMIT

This endorsement modifies the ACCIDENT MEDICAL EXPENSES REIMBURSEMENT BENEFIT section of the policy as follows:

1. The following is added to Section D. BENEFIT PROVISIONS under ACCIDENT MEDICAL EXPENSES REIMBURSEMENT BENEFIT:

"Chiropractic Care Sublimit: Notwithstanding the Limit of Insurance shown on the Schedule of Benefits, the maximum amount we will pay for chiropractic treatment is \$500 per policy period. This sublimit is part of, and not in addition to, the Accident Medical Expense Reimbursement Benefit limit shown on the Schedule of Benefits."

2. The following definition is added to Section C. POLICY DEFINITIONS:

"Chiropractic Treatment means treatment by a licensed chiropractor operating within the scope of his or her license, consisting of the manipulation and/or adjustment of the spine, skeletal articulations, and adjacent tissue."

ALL OTHER TERMS, CONDITIONS, AND EXCLUSIONS REMAIN UNCHANGED.