UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET ACCIDENT ONLY POLICY

POLICYHOLDER:	Faculty Student Association of Nassau Community College, Inc. Faculty Student Association of Nassau Community College, Inc. DBA Children's Greenhouse &/or Nassau Community College
POLICY NUMBER:	US1395999
POLICY EFFECTIVE DATE:	September 1, 2020
POLICY EXPIRATION DATE:	September 1, 2021

This Policy is issued in the state of New York and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain persons and pay benefits.

The Insurance Company and the Policyholder have agreed to all the terms of this Policy.

10 DAY RIGHT TO RETURN THIS POLICY

If for any reason, you are not satisfied with this Policy, you may return it to us within 10 days after receiving it. Upon its return, we will refund any premium paid and this Policy will be deemed void, just as though it had never been issued.

THIS IS ACCIDENT ONLY COVERAGE.
READ IT CAREFULLY.
BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.
THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.
THIS POLICY IS NOT RENEWABLE.

This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

Signed for **United States Fire Insurance Company** By:

Marc J. Adee

James Kraus

Chairman and CEO Secretary

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The following provisions appear within this Policy in the following order:

SCHEDULE OF BENEFITS

BENEFIT PERIOD:	**52 weeks from the date of the Covered Injury, provided the Expense occurs prior to the Expiration Date and care is Medically Necessary and while the Policy is in force.**
CLASS OF ELIGIBLE PERSONS:	**Class 1:** Eligible students of the Policyholder who have been assigned an NCC-ID number, including Policyholder intercollegiate student athletes, student managers and student coaches participating in Men's Baseball, Men's and Women's Basketball, Men's and Women's Cheerleading, Men's and Women's Cross Country, Women's Dance, Men's Football, Men's and Women's Golf, Men's and Women's Lacrosse, Men's and Women's Soccer, Women's Softball, Men's and Women's Tennis, Men's and Women's Track and Field, Women's Volleyball, and Men's and Women's Wrestling.

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum:	**$10,000**
Aggregate Limit Amount:	**$500,000**
Time Period for Loss:	**365 days**
Loss Period (first Covered Expenses must be incurred within):	**90 days after the Covered Accident or Injury**
Benefit Period:	**52 weeks from the date of the Covered Injury, provided the Expense occurs prior to the Expiration Date and care is Medically Necessary. and while the Policy is in force.**

ACCIDENT MEDICAL EXPENSE BENEFIT

Maximum Amount per occurrence per Covered Person	**$25,000**
Disappearing Deductible:	**$100**

The Disappearing deductible must be satisfied before this plan will pay benefits. Amounts paid by other carriers will be used to satisfy the deductible under this plan. With a Disappearing Deductible, any

amounts paid by other valid and collectible insurance toward the satisfaction of bills generated as a result of a covered accident will count toward satisfying the deductible. If the Covered Person's primary insurance makes any payment on an eligible expense, it counts toward the deductible, and amounts paid in excess of and applied to the deductible will cause the deductible to disappear or be reduced.

ACCIDENT MEDICAL EXPENSE BENEFITS

Hospital Room & Board Daily Maximum Benefit:	**100% of the Semi-Private Room Rate**
Intensive Care/Cardiac Care Room & Board:	**100% of URC**
Hospital Miscellaneous Benefit:	**100% of URC**
Pre-Admission Testing Benefit:	**100% of URC**
In-Patient Surgical Benefits:	
Primary Surgeons Maximum Benefit Amount:	**100% of URC**
Assistant Surgeon Benefit:	**100% of URC**
Out-Patient Surgery Benefits:	
Outpatient Primary Surgeons Maximum Benefit Amount:	**100% of URC**
Outpatient Assistant Surgeon	**100% of URC**
Outpatient Surgical Facility Maximum Benefit per	**100% of URC**
Emergency Room Benefit	**100% of URC**
Anesthesia Benefit:	**100% of URC**
Physician's Visits	
In-Hospital Maximum Benefit:	**100% of URC**
Physician's Visits	
Office Visits (Out-of-Hospital) Maximum Benefit:	**100% of URC**
X-Ray Benefit	**100% of URC**
Laboratory Benefit	**100% of URC**
Nursing Benefit Amount:	**100% of URC**
Outpatient Physiotherapy Benefit	**100% of URC**
Ground Ambulance Benefit Amount:	**100% of URC**

Dental Treatment For Injury Only
Benefit Amount: **100% of URC**

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under {these Additional Accident Benefits} shown below {are paid in addition to} any {Accidental Death and Dismemberment} benefits payable, unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.

The total of {all benefits payable under this Policy, including all Additional Accident Benefits} paid for all Injuries caused by the same Covered Accident shall not exceed the Principal Sum indicated in the *Schedule of Benefits* unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

Benefit payable per prescription **100% of URC**

DURABLE MEDICAL EQUIPMENT BENEFIT **100% of URC**

Home Health Care Benefit
Deductible Amount per calendar year: **$50**
Coinsurance per calendar year: **75%**
Maximum visits per calendar year: **40 4-hour visits**

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Policy. Additional terms may be defined within the provision to which they apply.

Accident means a sudden, unforeseeable external event which:
1. Causes Injury to one or more Covered Persons; and
2. Occurs while coverage is in effect for the Covered Person.

Aircraft means a vehicle which:
1. Has a valid certificate of airworthiness; and
2. Is being flown by a pilot with a valid license appropriate to the aircraft.

Amateur means a sport or activity where the participants engage largely or entirely without compensation.

Amateur mean any participant in a combative sport, who is not receiving or competing for, and who has never received or completed for, any purse, money, proze, pecuniary gain, or other thing of value exceeding seventy-five dollars or the allowable amount established by the authorized amateur sanctioning entity overseeing the competition. **(**Used with Combative Sports only)

Benefit Period means the period of time from the date of Injury, as shown in the Schedule of Benefits.

Club means an organization of students formed for the purpose of engaging in competition in a particular sport or activity. Competition between student clubs from different colleges, not organized by and therefore not representing the institution or their faculties.

Corridor Deductible means the dollar amount of the Covered Expenses the Insured person must pay towards the policy before We pay any benefits regardless of what any other Insurance Plan or other Insurance Carrier has paid. It applies separately for each Covered Person.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for the Usual, Reasonable and Customary charges for the Medically Necessary treatment, services and supplies covered by the Policy and Certificate and which is performed or given under the direction of a Physician for treatment of an Injury. Coverage under the Policy and Certificate must remain continuously in force from the date of the Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained. A Covered Expense for a an Injury cannot be in excess of the maximum benefit amount payable per service as shown in the Schedule and cannot be for medical services and supplies that are excluded under the Policy.

Covered Person means a person eligible for coverage as identified in the Application for whom proper premium payment has been made, and who is therefore insured under this Policy.

Dependent means the Insured's unmarried child who:

1. Chiefly relies on the Insured for support and maintenance; and
2. Is within the following age groups (unless otherwise shown in the Application):
    a. Under 19 years of age;
    b. 19 but less than 25 years of age and enrolled in a School as a full time student; or
    c. 19 or more years of age, and primarily supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap.

Child can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

Disappearing Deductible means a dollar amount of Covered Expenses the Insured Covered Person must pay before We pay any benefits. The Deductible may be satisfied by Other Valid and Collectible Insurance or Plan. The Disappearing Deductible is shown on the Schedule of Benefits.

Domestic Partner means an opposite or same sex partner for whom proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last 12 months, where such registry exists; or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
    a. The affidavit must be notarized and must contain the following:
        - The partners are both 18 years of age and are mentally competent to consent to contract;
        - The partners are not related by blood in a manner that would bar marriage under the laws of the State of New York;
        - The partners have been living together on a continuous basis prior to the date of the application;
        - Neither individual has been registered as a member of another domestic partnership within the last 12 months; and

    b. Proof of cohabitation (e.g. a driver's license, tax return or other sufficient proof); and

    c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
        - A joint bank account;
        - A joint credit card or charge card;
        - Joint obligation on a loan;

- Status as an authorized signatory of a partner's bank account, credit card or charge card;
- Joint ownership of holdings or investments;
- Joint ownership of residence;
- Joint ownership of real estate other than residence;
- Listing of both partners as tenants on the lease of the shared residence;
- Shared rental payments of residence (need not be shared 50/50);
- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc (need not be shared 50/50);
- Shared household budget for purposes of receiving government benefits;
- Status of one as representative payee for the other's government benefits;
- Joint ownership of major items of personal property (e.g. appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for child care (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, daycare, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other's life insurance policy;
- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while this Policy is in force.

He, his, and him includes she, her and hers.

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

1. Group or blanket insurance, whether on an insured or self-funded basis;
2. Hospital or medical service organizations on a group basis;
3. Health Maintenance Organizations on a group basis.
4. Group labor management plans;
5. Employee benefit organization plan;
6. Professional association plans on a group basis; or
7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

Hospital means an institution which:

1. Is operated pursuant to law;
2. Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
3. Is under the supervision of a staff of Physicians;
4. Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
5. Has medical, diagnostic and treatment facilities, with major surgical facilities;
    a. On its premises; or
    b. Available to it on a prearranged basis; and
6. Charges for its services.

7. Is a duly licensed Rehabilitation Facility.

Hospital does not include:
1. A clinic or facility for:
    a. Convalescent, custodial, educational or nursing care;
    b. The aged, drug addicts or alcoholics;
2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
    a. The services are rendered on an emergency basis; and
    b. A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Injury means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Interscholastic means a sport or activity organized between schools or representatives of the schools.

Intramural means a sport or activity within a particular institution and describes sports matches, activities, or contests that take place among teams from “within the walls” of an institution or area.

Immediate Family Member means the Covered Person’s parent (includes step-parent), Spouse, Child(ren) (includes legally adopted or step or Foster Child(ren), brother, sister, step-Child(ren), or in-laws.

Leased Aircraft means an aircraft for which the Policyholder or any of its subsidiaries or affiliates has a written lease under whose terms, the aircraft:
1. Can be used at the Policyholder's or any of its subsidiaries’ or affiliates’ discretion;
2. Can be used by the Policyholder or any of its subsidiaries or affiliates for 2 or more trips or for more than 10 consecutive days; and
3. Cannot be altered or sold by the Policyholder or any of its subsidiaries or affiliates, without the consent of the leaser or owner.

Leased Aircraft does not include any Owned Aircraft.

Life Threatening Brain Injury means an acute brain injury that, in the opinion of the professional licensee’s treating physician, would result in the death of the professional licensee if left untreated. The Company is only liable for Life Threatening Brain Injuries that are sustained in a program operated under the control of a licensed promotor. The symptoms of the Life Threatening Brain Injury must first manifest themselves during, or within twenty-four (24) hours after the end of, the licensed professional’s participation in the covered program, and the injury must be diagnosed by a Physician during, or within forty-eight (48) hours after the end of, the licensed professional’s participation in the covered program.

Medically Necessary or Medical Necessity means a treatment, service or supply that is:
1. Required to treat an Injury; and
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.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy or this Certificate.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, consider the cost of alternative to be the Covered Expense.

Nurse means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Operated or Controlled Aircraft means an aircraft which:
1. Has been leased, rented or borrowed by the Policyholder for at least 10 consecutive days, or more than 15 days in any one year;
2. Can be used at the Policyholder's discretion; and
3. Cannot be altered or sold by the Policyholder without the consent of the owner or leaser.

Operated or Controlled Aircraft does not include any Owned Aircraft.

Other Valid and Collectible Insurance means any reimbursement for or recovery of any element of Covered Expenses incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

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 services or injuries or diseases related to the Covered Person's job to the extent that he actually received benefits under a Worker's Compensation Law. If the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement.
5. Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after he or she becomes disabled while Insured hereunder.
6. 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.

Owned Aircraft means aircraft to which the Policyholder or any of its subsidiaries or affiliates holds legal or equitable title.

Physician means a person who is a qualified practitioner of medicine. A such, He or She must be acting within the scope of his/her license and under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person’s Spouse, son, daughter, father, mother, brother, or sister.

Physician means a practitioner of medicine under the laws of the state, country or territory where his or her medical services are performed and who is acting within the scope of such medical license at the time and place medical services are rendered. In the event medical services are performed in New York State, Physician shall mean a person who is a qualified practitioner of medicine. A such, He or She must be acting within the scope of his/her license and under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person’s Spouse, son, daughter, father, mother, brother, or sister.. *(to be used for Combative Sports or Professional Wrestling policies only)*

Principal Sum means the largest amount payable under the benefit for all losses resulting from any one Accident.

Professional Combative Sports means combative sports conducted under the supervision of the commission, under the supervision of an authorized sanctioning entity in compliance with all NY State Laws. Authorized combative sports include, amateur and professional boxing, wrestling, sparring, kick boxing, single discipline martial arts and mixed martial arts.

School means the participating School or School District where the Covered Person is enrolled or employed. The School must be a duly accredited (state certified or accredited) primary, elementary, secondary, or collegiate School.

Spouse means the lawful Spouse, if not legally separated or divorced, or Domestic Partneror Civil Partner, including same-sex partners legally married in other jurisdictions.

Supervised or Sponsored Activity means a Policyholder or School authorized function:
1. In which the Covered Person participates;
2. Which is organized by or under its auspices;

which is within the scope of customary activities for such entity and is shown on the Schedule of Benefits.

Usual, Reasonable and Customary means:
1. With respect to fees or charges, fees for medical services or supplies which are;
    a. Usually charged by the provider for the service or supply given; and
    b. The average charged for the service or supply in the locality in which the service or supply is received; or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

Waiting Period means the length of time from the date of loss to the time when benefits can be received.

ELIGIBILITY FOR INSURANCE

Eligibility:
Persons eligible to be insured under this Policy are those persons described as an ELIGIBLE CLASS on the Application. This includes anyone who may become eligible while this Policy is in force.

EFFECTIVE DATES OF INSURANCE

Policy Effective Date: The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date: A Covered Person will become an insured under this Policy, provided proper premium payment is made, on the latest of:
1. The Effective Date of the Policy; or
2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:
1. The Policy Termination Date shown in the Policy; or
2. The premium due date if premiums are not paid when due subject to any grace period.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

Termination:
Insurance for a Covered Person will end on the earliest of:
1. The date he is no longer in an Eligible Class.
2. The date he reports for active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    a. The date the premium is fully earned; or
    b. The Expiration Date of this Policy.
    This does not include Reserve or National Guard duty for training;
3. The end of the period for which the last premium contribution is made; or
4. The date this Policy is terminated.

Covered Person's Termination Date

Insurance for a Covered Person will end on the earliest of:

1. The date He is no longer in an Eligible Class.
2. The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    a. The date the premium is fully earned; or
    b. The Expiration Date of this Policy.
    This does not include Reserve or National Guard duty for training;
3. The end of the period for which the last premium contribution is made; or
4. The date this Policy is terminated; or
5. The date the Covered Person requests, in writing, that his/her coverage be terminated.

SCOPE OF COVERAGE

We will provide the benefits described in this Policy to all Covered Persons who suffer a covered loss which:
1. Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS** and results, directly and independently of disease or bodily infirmity, from an Injury which is suffered in an Accident;
2. Occurs while the person is a Covered Person under this Policy; and
3. Is within the scope of the risks set forth in the **DESCRIPTION OF HAZARDS** provisions.

Primary Medical Expense:
If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services on the SCHEDULE OF BENEFITS, we will pay the applicable benefit, subject to the Deductible Amount (if any).

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for treatment of a covered Injury:
1. While the person is insured under this Policy; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Eligible Expense must be incurred within the time frame stated on the SCHEDULE OF BENEFITS. The total of all medical benefits payable under this Policy is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

Non-Duplication of Benefits Provision:
This provision applies if a Covered Person:
1. Is covered by any other blanket or group health care plan; and
2. Would, as a result, receive total medical expense or service benefits in excess of the expenses actually incurred.

In this case, the medical expense benefits we will pay under this Policy will be reduced by such excess. This provision does not apply if we would be primary under any coordination of benefit guidelines contained in the other health care plans.

Non-Duplication of Benefits (Pro Rata) Provision:
If there are benefits under other insurance which apply to the same benefits as this coverage, we will pay a pro rata share of the total amount of benefits which are available. In no case shall the total benefits exceed 100% of the charges.

Pro rata share means the proportion of the total benefit that the amount payable under one policy in the absence of such other insurance bears to the total applicable benefits under all such policies.

Coordination of Benefits Provision:
If a Covered Person is also covered under one or more other Plans, the benefits payable under this Policy will be coordinated with the benefits payable under all other Plans.

Coordination of Benefits will be used to determine the benefits payable for a Covered Person for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of 1. and 2. below would exceed those Allowable Expenses:
1. The benefits that would be payable under this Policy without coordination; and
2. The benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans.

The benefits that would be payable under this Policy for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of:
1. Those required benefits; and
2. All the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses.

Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Policy are determined if:
1. The Benefit Determination Rules would require this Policy to determine its benefits before that Plan; and

2. The other Plan has a provision that coordinates its benefits with those of this Policy and would, based on its rules, determine its benefits after this Policy.

When Coordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a Covered Person, each benefit that would be payable in the absence of Coordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of this Policy.

We reserve the right to release to or obtain from any other insurance company or other organization or person, any information that, in our opinion, we or it needs for the purpose of the Coordination of Benefits. When payments that should have been made under this Policy based on the terms of this provision have been made under any other Plans, we have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under this Policy. We will be released from all liability under this Policy to the extent of these payments. When an overpayment has been made by us, at any time, we will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as we may determine.

Benefit Determination Rules - The rules below establish the order in which benefits will be determined:

1. **Benefits not as a Dependent:**
The benefits of a Plan that covers the person for whom claim is made other than as a dependent will be determined before a Plan that covers that person as a dependent.
2. **Dependent Benefits under Different Parent Plans:**
The benefits of a Plan that covers the person for whom claim is made as a dependent of the parent whose birthday falls earlier in the year will be determined before the benefits that covers that person as a dependent under the other parent's Plan.

When both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
However, if the other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
Notwithstanding the foregoing, in the case of a dependent child of divorced or separated parents, the following rules will apply:

a. If there is a court decree that establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan that covers the child as a dependent of the parent so responsible will be determined before any other Plan, otherwise:
b. The benefits of a Plan that covers the child as a dependent of the parent with custody will be determined before a Plan that covers the child as a dependent of a step-parent or a parent without custody;
c. The benefits of a Plan that covers the child as a dependent of a step-parent will be determined before a Plan that covers the child as a dependent of the parent without custody.

3. **Benefits for Person Longest Covered:**
When the above rules do not establish the order, the benefits of a Plan that has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time.

Whenever used in this provision:

Plan means a form of coverage written on an expense incurred basis that provides benefits or services for, or because of, medical care or treatment. Plan includes:
1. Group insurance and group or group remittance subscriber contracts;
2. Uninsured arrangements of group coverage;
3. Group coverage through HMO's and other prepayment, group practice and individual practice plans;

4. Blanket insurance coverage except blanket school accident coverages or such coverages issued to substantially similar group as defined in paragraph six of subsection (d) of section 52.70 of this Part where the policyholder pays the premiums;
5. Service plan contracts, group or individual practice or other prepayment plans;
6. Coverage under any labor management trusteed Plans, union welfare plans, employer organization plans, self-funded plans or employee benefit organization plans which provides medical or dental benefits or services; or
7. Medicare plan or similar governmental plan offering benefits, limited to the hospital,medical and surgical benefits of the governmental program. However, Plan shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.
8. Group and individual mandatory automobile “nofault” and traditional mandatory automobile “fault” type contracts.

It does not include coverage under individual policies or contracts. Each Plan or part of a Plan that has a right to coordinate benefits will be considered a separate Plan.

Primary Plan means one whose benefits for healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either:

1. the plan either has no order of benefit determination rules, or it has rules which differ from those in the Certificate; or
2. all plans that cover the person use the same order of benefits determination rules as in this contract, and under those rules the plan determines its benefits first.

Secondary Plan means one that is not the primary plan. If a person is covered by more than one secondary plan, the order of Benefit Determination Rules of this contract decide the order in which the benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan(s) and the benefits of any other plan which, under the rules of the Certificate, has its own benefits determined before those of that secondary plan.

Allowable Expense means any necessary, Usual, Reasonable and Customary item of expense for health care, at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Policy, and which allowable expenses are compared with total benefits payable in the absence of COB to determine whether over-insurance exists and how much each plan, including this plan, will pay or provide. For purposes of the Policy, the claim determination period will begin on the effective date of a Covered Person’s coverage and end 12 consecutive months following the date of loss unless extended by any proof of loss provision.

DESCRIPTION OF HAZARDS

HAZARD: SPORTS COVERAGE

Subject to all other provisions of this Policy, coverage is provided for a Covered Person while he is:
1. Taking part in:
    a. A regularly scheduled athletic game or competition; or
    b. A practice session for an athletic team or club;
2. Traveling to or from such a game, competition or practice session provided he is:

a. Traveling with the athletic team or club; and
b. Under the direct and immediate supervision of:
    i. The athletic team or club; or
    ii. An adult authorized by the athletic team or club; or

3. Traveling directly, without interruption
    a. Between his home and a scheduled game, competition or practice session;
    b. In a vehicle which is
        i. Designated or furnished by the athletic team or club;
        ii. Operated by a properly licensed, adult driver; or
        iii. Under the direct supervision of the athletic team or club; or
    c. In a vehicle other than that described in 3.b. when:
        i. Operated by a properly licensed driver; and
        ii. Travel time does not exceed 1 hour each way.

Travel time includes the time:
    i. To or from home, a scheduled game, competition or practice session;
    ii. Before required attendance time;
    iii. After the Covered Person is dismissed; and
    iv. After the Covered Person completes extra duties assigned by the School.

Covered athletic games or competition are shown on the Schedule of Benefits.

Injuries which result over a period of time (such as blisters, tennis elbow, etc.), and which are a normal, foreseeable result of the sport, are not covered.

Unless otherwise stated, we will pay benefits for a covered loss, only once, even if coverage was provided under more than one Description of Hazards.

HAZARD: SCHOOL COVERAGE - ALL SCHOOL ACTIVITIES

Subject to all other provisions of this Policy, insurance is provided for a Covered Person while he is:
1. On the School premises:
    a. While School is in session (including recess and lunch periods); or
    b. While School is not in session, if the Covered Person is involved in a Supervised or Sponsored Activity;
2. Away from School or home:
    a. If the Covered Person is involved in a Supervised or Sponsored Activity; and
    b. With adult supervision provided by the School;
3. Traveling directly, without interruption while attending or participating in a School sponsored field trip:
    a. Between his home and a scheduled game, competition or practice session;
    b. In a vehicle which is
        i. Designated or furnished by the athletic team or club;
        ii. Operated by a properly licensed, adult driver; or
        iii. Under the direct supervision of the athletic team or club; or
    c. In a vehicle other than that described in 3.b. when:
        i. Operated by a properly licensed driver; and
        ii. Travel time does not exceed 1 hour each way.

Travel time includes the time:
    i. To or from home, School, a Supervised or Sponsored Activity, a scheduled game, competition or practice session;
    ii. Before required attendance time;
    iii. After the Covered Person is dismissed; and
    iv. After the Covered Person completes extra duties assigned by the School.

When travel is by other than School bus, covered Travel Time shall not exceed 1 hour each way. This includes traveling to or from the Covered Person's home and School. The covered Travel Time includes the period before the Covered Person's required attendance time and the period after his dismissal or when he completes any extra duties.

Unless otherwise stated, we will pay benefits for a covered loss only once, even if coverage was provided under more than one Description of Hazards.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH DISMEMBERMENT

If, within 1 year(s) from the date of an Accident covered by this Policy, Injury from such Accident, results in Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing (both ears)	100%
Quadriplegia (total Paralysis of both upper and lower limbs)	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Hemiplegia (total Paralysis of upper and lower limbs on one side of body)	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of speech means total, permanent and irrecoverable loss of audible communication.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

Loss of speech means total, permanent and irrecoverable loss of audible communication.

Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Total Paralysis means complete loss of use and sensation of limbs. Paralysis must occur within the 180 day period from the date of the Covered Accident. The paralysis must be determined by a Physician to be complete and not reversible.

ACCIDENT MEDICAL and DENTAL EXPENSE BENEFITS

We will pay Accident Medical and Dental Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Benefit Periods,, benefit maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:
1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 90 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Eligible Medical Expenses, from a Covered Accident, include:

1. **Hospital room and board expenses**: charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

2. **Intensive Care/Cardiac Care Room and Board** - charges for each day of Intensive Care/Cardiac Care Unit confinement, up to the maximum benefit amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.

3. **Hospital Miscellaneous** – services, supplies and charges during a Hospital Stay, up to the maximum benefit amount shown in the Schedule of Benefits for the Hospital Miscellaneous Benefit. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

4. **Pre-Admission Testing Benefit** – charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing)

5. **In-Patient Surgical Benefits** - charges for:

    a. A Physician, for primary performance of a surgical procedure, up to the maximum benefit amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are

performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

b. A Physician, for: assistant surgeon duties up to the maximum benefit shown in the Schedule of Benefits for an Assistant Surgeon

6. Out-Patient Surgery Benefits:

We will pay this benefit when the Covered Person requires Outpatient Surgery to treat a Covered Loss resulting directly and independently from all other causes from a Covered Accident. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

Outpatient Surgery means the treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including the usual aftercare for such procedure, that is:

a. necessary for treatment of the Covered Person; and
b. given in the outpatient department of a Hospital or an ambulatory surgical center.

7. **Emergency Room** means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.
Emergency Room treatment includes all hospital related services including physician, x-ray and lab services shown in the Schedule of Benefits.

8. **Anesthesia Benefit** – Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis, up to the maximum benefit amount shown in the Schedule of Benefits for the Anesthesia benefit.

9. **Physician's Visits** - charges by a Physician for other than pre- or post-operative care:

a. For in-Hospital visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

b. For office visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

10. **X-Ray Benefit -** We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires x -ray examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

11. **Laboratory Benefit-** We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires laboratory examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

12. **Nursing Benefit**– Outpatient Charges for nursing services by a registered nurse or licensed professional nurse, up to the maximum benefit amount shown on the Schedule of Benefits for the Nursing benefit.

13. **Physiotherapy -** Charges for physiotherapy:
    a. As an outpatient, up to the maximum benefit amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

    Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy.

    Total treatment per Injury will not exceed the maximum benefit amounts for Physiotherapy shown in the Schedule of Benefits*.*

14. **Ground Ambulance** - for services billed by a professional ambulance company up to the Maximum Benefit Amount shown in Schedule of Benefits for the Ambulance benefit.
    Ground Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the injured from the scene of the Accident to a Hospital. Surface trips must be to the closest local facility that can provided the covered service appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area.
    Air transportation is covered when Medically Necessary because of a life threatening Injury.

15. **Dental Treatment for Injury Only** - Charges for dental treatment including dental x-rays for the repair and treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the maximum benefit amount shown in the Schedule of Benefits for the Dental Treatment benefit.

ADDITIONAL ACCIDENT BENEFITS

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses- shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:
1. Under Federal law may only be dispensed by written prescription; and
2. Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the out-patient use by the Covered Person:
1. On or after the Covered Person's Effective Date; and
2. By a licensed pharmacy provider.

Benefits are payable up to the maximum benefit amount shown on the Schedule of Benefits.

DURABLE MEDICAL EQUIPMENT BENEFIT

We will pay the benefit shown in the Schedule of Benefits if, by reason of Injury, a Covered Person requires the use of Durable Medical Equipment.

Durable Medical Equipment means medical equipment that:
1. is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;

2. can withstand long-term repeated use without replacement;
3. is not useful in the absence of the Covered Injury and
4. can be used in the home without medical supervision; and
5. the purpose of the equipment is not to help the Covered Person participate in sports activity.

HOME HEALTH CARE

We will pay the benefit amount shown in the Schedule of Benefits for Home Health Care as the result of a Covered Accident.

Home Health Care means nursing care, treatment provided in the Covered Person's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

1. the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care; and Necessary care and treatment are not available from a Covered Person's Immediate Family Member or other persons residing with the Covered Person without causing undue hardship;
2. nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service.

Home Health Care consists of, but shall not be limited to, the following:

a. Part time and intermittent skilled nursing services: services given to the Covered Person at least once every 60 days or as frequently as a few hours per day, several days per week.

b. Therapeutic services: physical therapy occupational therapy; speech and hearing therapy; and

c. Medical social services, medical supplies, drugs and medicines, related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under this Certificate if the Covered Person had remained in the Hospital.

EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under this Policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty in any Armed Forces, National Guard, military, naval or air service or organized reserve corps:
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro-rata premium upon request;
5. Participation in a riot or insurrection.
6. Disease or disorder of the mind including mental or nervous disorders.
7. Loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of the Covered Person's Physician.

8. Commission or attempt to commit a felony.
9. Injuries paid under Workers' Compensation, Employers liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
10. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
11. Travel or activity outside the United States and its territories, or the countries of Canada and Mexico.
12. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 12 months of the Accident..
13. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore.
14. Aviation, except as a far paying passenger on a scheduled or chartered flight operated by a scheduled airline.
15. a. an ultralight hang gliding, parachuting, or bungi cord jumping
16. Rest cures or custodial care.
17. Elective or Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
18. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto} of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

LIMITATIONS

Any benefits payable under this Certificate will be limited to the following:

(1) The medical benefits otherwise payable under this Certificate will be reduced by 50% if:
   (a) Excess insurance is provided under this Certificate; and
   (b) The Covered Person has coverage under another plan providing medical expense benefits; and
   (c) The other plan is an HMO, PPO or similar arrangement ("PPO-Preferred Provider Organization" means an Organization offering health care services through designated health care providers who agree to perform these services at rates lower than nonpreferred providers.); and
   (d) The Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement for the provision of benefits.

   The Covered Person's limitation does not apply to emergency treatment required within 24 hours after an Accident which occurred outside the geographic area serviced by the HMO, PPO or similar arrangement.

(2) In the event no consenting surgical opinion is obtained for those procedures that mandate such second surgical opinion benefits payable for all Eligible Expenses associated with the procedure will be reduced by 50%. This limitation will apply whether the surgery is performed on an in-patient or out-patient basis. We will not cover a second opinion given more than 6 months after surgery was first recommended.

(3) Costs that exceed the Usual, Reasonable and Customary charges in the area where the services are furnished or supplies provided. Services, supplies and equipment must be:
   (a) Medically necessary for the care or treatment of a covered Injury;
   (b) Received while coverage is in force under this Certificate; and
   (c) Rendered and/or prescribed by a licensed Physician other than the Covered Person 9or a member of his household or immediate family) in accordance with current medical standards and practices.

(4) The application of the Coordination of Benefits or Non-Duplication of Benefits provision.

(5) If the Covered Person is admitted into the Hospital on a Friday or a Saturday on a non-emergency basis and the procedure for which he is admitted is not performed on the day of or the day after admission, we will not pay the Hospital cages for room and board or miscellaneous Hospital charges for the initial Friday or Saturday preceding the procedure.

AGGREGATE LIMIT

The Aggregate Limit Amount is shown in the Application. We will NOT be liable for any amount over such limit for any one Accident.

If the total amount of benefits to be paid under this Policy is more than the Aggregate Limit Amount, the benefit amount payable for a Covered Person's loss will be determined as a proportionate share of the Aggregate Limit Amount.

PREMIUM PROVISIONS

GRACE PERIOD:
A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period unless notice has been sent, in accordance with the POLICY TERMINATION provision, of the intent to terminate coverage under this Policy. Coverage will end if the premium is not paid by the end of the grace period.

PREMIUMS:
Premium due dates are the first of every month. Premium payment made in advance or for more than a one month period will not affect any provisions of this Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

CHANGES IN RATES:
We have the right to change the premium rates on any premium due date:
1. After the first 12 months insurance is in effect;
2. Coinciding with a change in the coverage provided or classes eligible; or
3. Coinciding with a change in the risks we have assumed.

We will give 31 days written notice of any change under 1. above. Notice will be sent to the Policyholder's most recent address in our records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
This Policy, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at our option, may also be made a part of this contract.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2 years from the Covered Person's

effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in this Policy will be valid until approved by one of our executive officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:
This Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

RECORDS MAINTAINED:
The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person's insurance under this Policy.

We shall be permitted to examine the Policyholder's records relating to coverage under this Policy. Examination may occur at any reasonable time up to the later of:
1. The two year period after the expiration of the Policyholder's coverage; or
2. The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:
The Policyholder or its authorized agent must report to us, by the premium due date:
1. The names of all persons insured on the Effective Date of this Policy;
2. The names of all persons who are insured after the Effective Date of this Policy;
3. The names of those persons whose insurance has terminated; and
4. Additional information required as agreed to by us and the Policyholder.

NEWLY ACQUIRED SUBSIDIARIES:
The premium for this Policy applies to the risks assumed on the Effective Date of this Policy. Eligible employees or members of subsidiaries newly acquired through merger, stock purchase, exchange of stock, or otherwise, shall be insured under this Policy, subject to the following conditions:
1. The Policyholder has at least 50% controlling interest in the subsidiary.
2. An additional premium payment is required with a report to us and the name of any newly acquired subsidiary.
3. Necessary underwriting information must be furnished for us to determine the additional risks assumed.
4. Coverage will begin on the legal date of acquisition.

No coverage shall continue for more than 60 days after the legal acquisition date unless the required report with the necessary data is supplied and the additional premium paid. The Policyholder shall be liable for payment of premium for the period during which such coverage remains in effect.

POLICY TERMINATION:
We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

CONFORMITY WITH STATE STATUTES:
Any provision of this Policy in conflict, on the Effective Date of this Policy, with the laws of the state where it is delivered, is amended to conform to the minimum requirements of such laws.

CLAIM PROVISIONS

NOTICE OF CLAIM:
Written notice must be given to us within 30 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given at our administrative office as shown on the cover page or to our agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

CLAIM FORMS:
When we receive the notice of claim, we will send forms for filing proof of loss. If claim forms are not sent within 15 days after notice is given, the proof requirements will be met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:
Written proof of loss must be furnished to us in the case of a claim for loss for which this Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 120 daysafter the date of such loss.

If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible.

TIME OF PAYMENT OF CLAIMS:
Benefits due under this Policy for a loss, other than a loss for which this Policy provides installments, will be paid within 60 days of receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which this Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

PAYMENT OF CLAIMS:
Benefits for a Covered Person's loss of life will be paid to the beneficiary named in our records, if any, at the time of payment. The benefits can be paid in one sum or, at a Covered Person's written request, in accordance with one of our settlement plans. If a Covered Person has not requested any settlement plan, the beneficiary can do so in writing after a Covered Person's death. If there is no named beneficiary or surviving beneficiary, a Covered Person's loss of life benefits will be paid in one sum to the first surviving class of following in the order shown below:

1. The beneficiary named to receive a Covered Person's proceeds;
2. Spouse;
3. Child or children;
4. Mother or father;
5. Sisters or brothers; or
6. The estate of a Covered Person.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Covered Person's death may, at our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

PAYMENT OF CLAIMS: OTHER BENEFITS:
All other benefits will be paid to the Covered Person, if he is living, if not, we will pay his beneficiary or his estate.

CHANGE OF BENEFICIARY: (Applicable only if an Accidental Death or Dismemberment benefit is provided)
The Insured can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change which a Covered Person may make unless the designation of beneficiary is irrevocable or otherwise required by law.

CONDITIONAL CLAIM PAYMENT:
If a Covered Person incurs expenses for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will pay benefits if:
1. The Covered Person first agrees in writing to refund the lesser of:
    a. The amount we actually paid for such expenses; or
    b. The amount actually received from the third party for such expenses; and
2. The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, prior to our payment of benefits under this Policy, if the third party's liability is satisfied in an amount less than the benefits payable under this Policy, we will pay the difference.

PHYSICAL EXAMINATION AND AUTOPSY:
We will pay the cost and have the right to have the Covered Person examined as often as reasonably necessary while the claim is pending. We can have an autopsy made at our expense unless prohibited by law. (Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.)

RECOVERY OF BENEFITS:
We reserve the right to recover from a Covered Person any benefits we have paid to him for injuries:
1. Received in a covered Accident; and
2. Which are covered under:
    a. workers' compensation or similar statutory remedies available under law; or
    b. Any employer's liability Insurance.

It will be assumed that the Covered Person is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

LEGAL ACTIONS:
No action at law or in equity shall be brought to recover benefits under this Policy less than 60 days after written proof of loss has been furnished as required by this Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

FRAUD WARNING STATEMENT

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY:

Application: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Claim Form: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO and PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

NEW YORK*: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee Signature _____ Date _____

*The fraud warning in NY must appear above the signature line.

THE UNITED STATES FIRE INSURANCE COMPANY
Administrative Office: 5 Christopher Way • Eatontown, NJ 07724

NEW YORK
EXTERNAL APPEAL

YOUR RIGHT TO AN EXTERNAL APPEAL
Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State of New York to conduct such appeals.

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY
If we have denied coverage on the basis that the service is not medically necessary, you may appeal to an external appeal agent if you satisfy the following two criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate; and

- You must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial **or** we and you must agree to waive any internal appeal.

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL
If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two criteria:

- The service must otherwise be a Covered Service under the Certificate; and

- You must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial **or** we and you must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one that, according to the current diagnosis of your attending physician, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered under the Certificate or one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State of New York in order to obtain current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

THE EXTERNAL APPEAL PROCESS

If, through the first level of our internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and we have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. We will provide an external appeal application with the final adverse determination issued through the first level of our internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Insurance Department at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which we based our denial, the external appeal agent will share this information with us in order for to exercise our right to reconsider its decision. If we choose to exercise this right, we will have three business days to amend or confirm our decision. Please note that in the case of an expedited appeal (described below), we do have a right to reconsider our decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or from us. If the external appeal agent requests additional information, it will have five additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and us by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns our decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, we will provide coverage subject to the other terms and conditions of the Certificate. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not

be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and us. The external appeal agent's decision is admissible in any court proceeding.

At our option, we may choose to charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. We will waive the fee if we determine that paying the fee would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee will be refunded to you.

YOUR RESPONSIBILITIES

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Insurance Department. You may appoint a representative to assist you with your external appeal request, however, the Insurance Department may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Plan has no authority to grant an extension of this deadline.

COVERED SERVICES/EXCLUSIONS

In general, we do not cover experimental or investigational treatments. However, we will cover an experimental or investigational treatment approved by an external appeal agent in accordance with the terms of the Certificate. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs that would not be covered under the Certificate for non-experimental or non-investigational treatments provided in such clinical trial.

Signed for **The United States Fire Insurance Company** By:

Marc J. Adee
Chairman & CEO

When used throughout this document “The Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Crum & Forster A&H Division
5 Christopher Way, 2nd Floor
Eatontown, New Jersey 07724