BLANKET ACCIDENT ONLY POLICY

POLICYHOLDER: University of Maryland, Baltimore

POLICY NUMBER: US096570

POLICY EFFECTIVE DATE: August 1, 2019

POLICY EXPIRATION DATE: August 1, 2020

This Policy is issued in the state of Maryland 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.

Signed for United States Fire Insurance Company By:

Marc J. Adee  
Chairman and CEO

James Kraus  
Secretary
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**SCHEDULE OF BENEFITS**

**BENEFIT PERIOD:** 52 weeks

**POLICY AGGREGATE BENEFIT AMOUNT:** $50,000 per Injury

**CLASS OF ELIGIBLE PERSONS:** Class 1: All active members of the policyholder are eligible

**ACCIDENTAL DEATH AND DISMEMBERMENT**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Sum</td>
<td>$10,000</td>
</tr>
<tr>
<td>Time Period for Loss</td>
<td>365 days</td>
</tr>
<tr>
<td>Loss Period (first Covered Expenses must be incurred within)</td>
<td>90 days after the Covered Accident or Injury</td>
</tr>
</tbody>
</table>

**ACCIDENT MEDICAL EXPENSE BENEFIT**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Amount per occurrence per Covered Person</td>
<td>$50,000</td>
</tr>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
</tbody>
</table>

*Deductible* means a dollar amount of Covered Expenses the Covered Person must incur before becoming eligible for policy benefits. The Deductible may be satisfied by Other Valid and Collectible Insurance or Plan.

**ACCIDENT MEDICAL EXPENSE BENEFITS**

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Room &amp; Board Daily Maximum Benefit</td>
<td>100% of the Semi-Private Room Rate</td>
</tr>
<tr>
<td>Intensive Care/Cardiac Care Room &amp; Board</td>
<td>100% of URC</td>
</tr>
<tr>
<td>Hospital Miscellaneous Benefit</td>
<td>100% of URC</td>
</tr>
<tr>
<td>Pre-Admission Testing Benefit</td>
<td>100% of URC</td>
</tr>
</tbody>
</table>

**In-Patient Surgical Benefits**

| Description                                                                 | Benefit Type          |
| 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 Maximum Benefit: 100% of URC
Outpatient Surgical Facility Maximum Benefit: 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

Ambulance Benefit Amount: 100% of URC

Dental Treatment for Injury Only Benefit Amount: 100% of URC, up to $10,000

Prosthetic Devices and Repairs 100% of URC, up to $100.00

Hearing Aid Benefit 100% of URC, up to $1,400.00 per hearing aid for each hearing-impaired ear every 24 months.

Ostomy Equipment and Supplies 100% of URC, up to $100.00

Home Health Care Benefit: 100% of URC, up to $50,000

ADDITIONAL ACCIDENT BENEFITS
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: $50,000 maximum

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.

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

**Bereavement Counseling** means counseling provided to the Immediate Family or Family Caregiver of the Covered Person after the Covered Person’s death to help cope with the death of the 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 which is performed or given under the direction of a Physician for treatment of an Injury. 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 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 for whom proper premium payment has been made, and who is therefore insured under this Policy.

**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.

**Family Caregiver** means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill person.

**Family Counseling** means counseling given to the Immediate Family or Family caregiver of the terminally ill person for the purpose of learning to care for the Covered Person and to adjust to the death of the Covered Person.

**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

**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;
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.

**Immediate Family Member** means the Covered Person's parent (includes step-parent), grandparent, Spouse, Child(ren) (includes legally adopted or step or Foster Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws. A Member of the Immediate Family includes an individual who normally lives in the Covered Person's household.

**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 purchasing or renting 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.

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.

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, at our discretion, 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.).

**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 Hospital, medical or other health services for 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 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.

6. 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.

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** 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 or other relative.

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

**Respite Care** means temporary care provided to a terminally ill person to relieve the Family Caregiver from the daily care of the Covered Person.

**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.

**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.

**Terminally Ill** means a medical prognosis given by a Physician that the Covered Person’s life expectancy is 6 months of less.

**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.

**ELIGIBILITY FOR INSURANCE**

**Eligibility:**
Persons eligible to be insured under this Policy are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits. 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 last day of the grace period, if the premium is not paid by the last day of the grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid.

The Policy may be terminated by the Company as of any premium due date or Policy Anniversary Date by giving written notice to the Policyholder at least 45 days prior to such date.

**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. This does not include Reserve or National Guard duty for training;
3. The date this Policy is terminated.

**Extension of Benefits for Total Disability**
If a Covered Person is Totally Disabled when the coverage terminates, we shall continue to pay covered benefits, in accordance with the Policy in effect at the time the Covered Person's coverage terminates, for expenses incurred by the Covered Person for the condition causing the disability until the earlier of:

(i) the date the Covered Person ceases to be Totally Disabled; or

(ii) 12 months after the date coverage terminates.

The Covered Person must provide the Company proof that He or She is Totally Disabled.

**Extension of Dental Benefits**

If a Covered Person’s coverage terminates, We shall continue to pay covered benefits for a course of dental treatment for at least 90 days after the date coverage terminates if the treatment:

(i) begins before the date coverage terminates; and

(ii) Requires two or more visits on separate days to a dentist's office.

**Extension of Benefits for Hospital Confinement**

If a Covered Person’s coverage terminates while the Covered Person is confined in a hospital, We shall continue to pay covered benefits, in accordance with the Policy in effect at the time the Covered Person’s coverage terminates, for the confinement until the earlier of:

(i) the date the Covered Person is discharged from the hospital, or;

(ii) 12 months after the date coverage terminates.

**Extension of Benefits for Accident Death and Dismemberment**

We shall provide covered benefits, in accordance with the Policy in effect at the time the Covered Person’s coverage terminates, for a covered loss that occurs after the date coverage terminates if:

(i) a covered accident occurs while the Covered Person is covered, and;

(ii) the loss occurs within 90 days after the covered accident.

**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. The accident occurs while the coverage is in force; and
3. Is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

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:
A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
1) 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.

2) 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.

B. In the case of a dependent child of divorced or separated parents, the following rules will apply:
   1) 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, if the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but the parent’s spouse does, that parent’s spouse’s plan will be determined before any other Plan;
   2) If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of Subparagraph A above.
   3) If a court decree states that both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provision of Subparagraph A above shall determine the order of benefits; or
   4) If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
      a. The plan covering the custodial parent
      b. The plan covering the custodial parent’s spouse;
      c. The plan covering the non-custodial parent; and then
      d. The plan covering the non-custodial parent’s spouse.

C. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph A and B of this section, as if those individuals were the parents of the child.

3. **Active Employees or Retired or Laid-Off Employee**
   A. The benefits of a plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee will be determined before any plan that covers that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee.

4. **COBRA or State Continuation Coverage**
   A. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or federal law is covered under another plan, the benefits of the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member subscriber or retiree will be determined before any plan covering that same person pursuant to COBRA or under a right o continuation pursuant to state or other federal law.

5. **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.

   To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

   The state of a new plan does not include:
1) A change in the amount or scope of a plan’s benefits;  
2) A change in the entity that pays, provides or administers the plan’s benefits; or  
3) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

The person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine length of time the person’s coverage under the present plan has been in force.

6. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

Whenever used in this provision:

**Plan** means any:
1. Group, blanket or franchise insurance coverage;
2. Service plan contracts, group or individual practice or other prepayment plans;
3. 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
4. Medicare plan or similar governmental plan offering benefits.

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.

**Allowable Expense** means any necessary, Usual, Reasonable and Customary item of expense 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.

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**DESCRIPTION OF HAZARDS**

**HAZARD: SCHOOL COVERAGE**

Subject to all other provisions of this Policy, insurance is provided for a Covered Person while he is attending School.

The Covered Person must be:
1. On School premises:
   a. During School hours on school days;  
   b. During lunch and recess periods; and
2. Not on School premises and attending or participating in a School sponsored field trip 1 day duration; or
3. Traveling directly, without interruption while attending or participating in a School sponsored field trip:
   a. Between his home and School on days when he is scheduled to attend; and
   b. In a vehicle which is:
      i. Designated or furnished by the School;  
      ii. Operated by a properly licensed adult driver; and
iii. Under the direct supervision of the School;

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 12 hour(s) each way.

Travel time includes the time:
   i. To or from home and School;
   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 12 hours 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 AND DISMEMBERMENT
If, within 1 year 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.

<table>
<thead>
<tr>
<th>Loss</th>
<th>Percentage of Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Both Hands</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Entire Sight of Both Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of One Hand and One Foot</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of One Hand and Entire Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of One Foot and Entire Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of One Hand</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of One Foot</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Entire Sight of One Eye</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Thumb and Index Finger of the Same Hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

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 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.
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 30 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. Charges covered for hospital services rendered will be done on the basis of the rate approved by the Health Services Cost Review Commission.

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. Ambulance - for services billed by a professional ambulance company up to the Maximum Benefit Amount shown in Schedule of Benefits for the Ambulance benefit.

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.

16. Prosthetic Devices and Repairs Benefits - will be paid the same as any other Accident service for Covered Persons for prosthetic devices, components of prosthetic devices and repairs. Benefits will only be payable for the most appropriate Medically Necessary model that adequately meets the needs of the Covered Person. In this section, “prosthetic device” means an artificial device to replace, in whole or in part, a leg, an arm or an eye.

Benefits are subject to all Deductible, copayment, coinsurance, limitations or any other provisions of this Policy. Any such provisions and limitations will not be more restrictive that the limitations and medical necessity established under the Medicare coverage database.

17. Hearing aids – coverage for hearing aids as defined in this Policy, when damage occurs in a Covered Accident that requires medical treatment. Coverage for hearing aids for a Dependent child who is covered under the Policy will be provided if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. We may limit the benefit payable for hearing aids to $1,400 per hearing aid for each hearing-impaired ear every 24 months.

18. Ostomy Equipment and Supplies – coverage for all medically appropriate and necessary equipment and supplies used for the treatment of ostomies, including flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies.

19. 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, but not less than 40 visits in a calendar year or in a continuous 12 month period.

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 Policy if the Covered Person had remained in the Hospital.

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.

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, 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. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural foreseeable result of an Accidental external bodily injury or accidental food poisoning.
6. Disease or disorder of the body or mind.
7. Conditions that are not caused by a Covered Accident.
8. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
9. Any treatment, service or supply not specifically covered by this Policy.
10. Loss resulting from participation in any activity not specifically covered by this Policy.
11. Charges which are in excess of Usual, Reasonable and Customary charges.
12. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
13. Regular health checkups.
14. Services or treatment rendered by a Physician, Nurse, or any other person who is employed or retained by the Policyholder.
15. Services or treatment rendered by an Immediate Family member of the Covered Person;
16. 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. This does not apply to benefits provided by Medicaid.
17. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
18. Treatment of a hernia whether or not caused by a Covered Accident.
19. Expense incurred for treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofascial pain, except as specifically provided in this Policy.
20. 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 6 months of the Accident.
21. Eyeglasses, contact lenses, appliances, or examinations or prescriptions therefore.
22. Travel in or upon:
   a. A snowmobile;
   b. Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
   c. Any off-road motorized vehicle not requiring licensing as a motor vehicle.
23. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
   a. A space craft or any craft designed for navigation above or beyond the earth’s atmosphere; or
   b. An ultralight hang-gliding, parachuting, or bungi-cord jumping

   Except as a fare paying passenger on a regularly scheduled commercial airline.
24. Practice or play in any school sports activity or professional sports contest or competition.
25. Rest cures or custodial care.
26. Prescription medicines unless specifically provided for under this Policy.
27. Elective or Cosmetic surgery, except for reconstructive surgery on an injured part of the body.

**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 at least 45 days before the premium is due, of the intent to terminate coverage under this Policy. Coverage will end on the last day of the grace period. During the grace period the Policy shall continue in force.

**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 grace period.

**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 **45 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. 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.

**CONTESTABILITY OF COVERAGE:**
This policy cannot be contested, except for non-payment of premium, after it has been in force for two years from the date of issue.

**MISSTATEMENT OF AGE:**
If benefits for the Covered Person are based on age and the Covered Person's age has been misstated, there will be a fair adjustment of benefits based on the Covered Person's true age. The Company may require satisfactory proof of age before paying any claim.

**STATEMENT IN APPLICATIONS:**
Absent fraud, all statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. A statement made by the Policyholder will not be used in defense to a claim under the policy unless the statement is contained in a written application.

**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.

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. If written notice cannot be given to us within the 30 day period, we may not invalidate
or reduce a claim if the Covered Person can show Us that it was not possible to provide Us with the notice,
and it was provided 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 90 days after 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 not more than 30 days after 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 $5,000 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.

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.

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.

**SUBROGATION:**
If we have paid benefits to a Covered Person for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents.

In the event, We do not file a petition to intervene in a corresponding personal injury action, and are not independently represented by counsel, the amount recoverable by Us under this provision shall be reduced by a percentage equal to that incurred by the Covered Person for attorney fees as compared to the settlement amount. At no time will this percentage exceed one-third. Upon receipt of a request to reduce a subrogation claim, we shall require a certification confirming the amount of applicable attorney fees.

**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.