UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET ACCIDENT ONLY POLICY

POLICYHOLDER:	**Mt. San Antonio Community College District**
POLICY NUMBER:	**US2152388**
POLICY EFFECTIVE DATE:	**July 1, 2025**
POLICY EXPIRATION DATE:	**June 30, 2026**

This Policy is issued in the state of **CALIFORNIA** 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.

NOTICE

THIS NOTICE IS TO ADVISE THE POLICYHOLDER THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING THIS POLICY, YOU MAY CONTACT UNITED STATES FIRE INSURANCE COMPANY AT 5 CHRISTOPHER WAY EATONTOWN, NEW JERSEY 07724 or CALL (732) 676-9800

ALSO AVAILABLE IS THE CONSUMER SERVICES DIVISION OF THE CALIFORNIA DEPARTMENT OF INSURANCE, WHICH MAY BE CONTACTED AS FOLLOWS: CALIFORNIA DEPARTMENT OF INSURANCE CONSUMER SERVICES DIVISION; 300 SPRING STREET, SOUTH TOWER LOS ANGELES, CALIFORNIA 90013 or call 1-800-927-HELP or 1-800-927-4357

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

Required Disclosure under California Insurance Code 10270.3: Please note that all benefits payable under this Policy may be subject to reduction, to the extent provided in this Policy, to the extent that you are entitled to benefits, whether on an indemnity basis or on a provision-of-service basis, for hospital, medical, dental, or surgical expenses under any other valid and collectible individual, group or blanket insurance policy or contract, hospital or medical service program, or group-practice pre-payment plan, except for automobile medical payments insurance.

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

Michael P. McTigue
Secretary

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

SCHEDULE OF BENEFITS

BENEFIT PERIOD:	**10 years from the date of the Covered Injury, provided the Injury occurs prior to the Expiration Date and care is Medically Necessary**
CLASS OF ELIGIBLE PERSONS:	**Class 1: All registered student athletes, student coaches, student managers and student trainers of the policyholder** **Class 2: All registered students of the policyholder, excluding student athletes, student trainers, student managers and student coaches of the policyholder. Enrolled dependent children of registered student who are attending the policyholder's on-campus day care facility.**

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum:	**$10,000**
Aggregate Limit Amount:	**$500,000**
Time Period for Loss:	**365 days**

CATASTROPHIC CASH BENEFIT	**$1,000,000**

ACCIDENT MEDICAL EXPENSE BENEFIT

Maximum for all Accident Medical	**$1,000,000**
Disappearing Deductible:	**Class 1: $25,000** **Class 2: $50,000**

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 Usual, Reasonable & Customary Charges, (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 Maximum Benefit:	**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**
Ambulance Benefit Amount:	**100% of URC**
Dental Treatment For Injury Only Benefit Amount:	**100% of URC**
OUT-PATIENT PRESCRIPTION DRUG BENEFIT	
Benefit payable per prescription	**100% of URC**

REHABILITATION EXPENSE BENEFIT	
Benefit per Covered Accident	**100% of URC**
DURABLE MEDICAL EQUIPMENT BENEFIT	**100% of URC**

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.

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

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.

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 of which an Accident is the proximate cause. 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/Domestic Partner, 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
1. A treatment, service or supply that is require to treat an Injury;
2. Prescribed or ordered by a Physician or furnished by a Hospital;
3. Performed in the least costly setting required by the condition;
4. Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

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.

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/Domestic Partner, 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.

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 the amount that is the normal payment range for a specific medical procedure performed within a given geographic area. If the charges submitted are higher than what is considered normal for the covered services, then We may not allow the full amount charged.

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 premium due date if premiums are not paid when due subject to any 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 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 is a proximate result 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.

Full Excess Medical Expense:
If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, we will pay the Eligible Expenses incurred, subject to the Deductible Amount (if any), that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the 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 Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Policy is shown on the SCHEDULE OF BENEFITS: and
1. Subject to the specific maximums shown on the SCHEDULE OF BENEFITS; and
2. Subject to compliance with the requirement, set forth in the Limitations section of this Policy.

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 covered under a Policy issued to a School, as the Policyholder and 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 12 hour(s) 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 12 hour(s) 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

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
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.

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

CATASTROPHIC CASH BENEFIT

If a Covered Person suffers a covered Accident that results in a covered Injury that causes the Covered Person to experience Total Paralysis, Coma or Brain Death within 180 days from the date of the Accident, the Company will pay a maximum benefit as stated in the Schedule of Benefits. The Injury must be a proximate cause of the covered Accident and the condition must continue for 6 consecutive months to be eligible for benefits.

A lump-sum benefit of up to $200,000 will be paid after said conditions continue for 6 consecutive months. Thereafter, a yearly benefit of $50,000 will be paid for the lifetime of the Insured Person, not to exceed 16 years, so long as the Insured Person remains with Total Paralysis, in a Coma, or has incurred irreversible Brain Death, not to exceed the Maximum Benefit. Benefits will be paid on a monthly basis.

Brain Death means an irreversible cessation of all functions of the entire brain, including the brain stem, even though the heart is still beating.

Coma means total loss of use of the body or being in a state of profound unconsciousness which was a proximate cause from an Accident, and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Accident.

Under no circumstances will the Company pay more than the Covered Person's Principal Sum for all Covered Losses combined, including this Coma Benefit, which are incurred as the result of the same Accident.

The Covered Person's designated beneficiary is responsible for providing the Company proof of continuing Coma. The Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Covered Person is in a Coma, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

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, Reasonable 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, Reasonable and Customary Charges.

Eligible Medical Expenses, from a Covered Accident, include:

1. **Hospital room and board expenses**: charges for 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 which was a proximate cause 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. We will pay the provider of transportation for medical services directly if the provider has not received payment for those services from any other source.

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.

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.

REHABILITATION EXPENSE BENEFIT

If a Covered Person suffers a Covered Loss the Company will reimburse the Covered Person for expenses incurred within one years after the date of the Covered Accident causing such loss, per Accident, which are charged for:
1. physical, occupational, speech or hearing therapy, or other rehabilitation training for which measurable improvement is expected within a reasonable time; and
2. Medically Necessary services or supplies related to rehabilitation therapy.

The therapy, training, services or supplies must:
1. meet generally accepted standards of medical practice;
2. be provided in a duly licensed Rehabilitation Facility; and
3. be provided by or under the supervision of a Physician.

Only one Rehabilitation Expense Benefit will be paid regardless of the number of Covered Losses incurred as the result of the same Covered Accident.

The Company will not reimburse expenses:
1. for which no charge would have been made if no insurance existed;
2. in excess of the Usual, Reasonable and Customary Charges for similar services in the locality where the services are received; or
3. as the result of an Injury caused by an Accident for which the Covered Person is entitled to benefits paid or payable by Workers' Compensation or other similar law.

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 directly resulting in whole or part from, 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. 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.
5. Mental or nervous disorders.
6. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician and not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
7. Intoxication or being under the influence of any drug or narcotic.
8. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
9. Driving under the influence of a controlled substance unless administered on the advice of a Physician.
10. Driving while Intoxicated. Intoxicated will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.
11. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
12. Conditions that are not caused by a Covered Accident.
13. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
14. Any treatment, service or supply not specifically covered by this Policy.
15. Loss resulting from participation in any activity not specifically covered by this Policy.
16. Charges which Are in excess of Usual, Reasonable and Customary charges.
17. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
18. Regular health check ups.
19. Services or treatment rendered by a Physician, Nurse, or any other person who is employed or retained by the Policyholder.
20. Services or treatment rendered by an Immediate Family member of the Covered Person;
21. 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.
22. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
23. Treatment of a hernia whether or not caused by a Covered Accident.
24. Damage or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
25. 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.
26. 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. .
27. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore.
28. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    a. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    b. While being used for any test or experimental purpose; or
    c. While piloting, operation, learning to operate or serving as a member of the crew thereof; or
    d. While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.

e. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
f. an ultralight hang-gliding, parachuting, or bungi-cord jumping

Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.

29. Rest cures or custodial care (Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets and supervision of medications which are ordinarily self-administered.
30. Elective or Cosmetic surgery, except for reconstructive surgery on an injured part of the body.

MEDICAL REVIEW REQUIREMENTS

A Covered Person may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance if he or she believes that we have improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under the Covered Person's coverage that has been denied, modified, or delayed by us, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available. There is no application or processing fee of any kind for an IMR. The Covered Person has the right to provide information in support of the request for an IMR. We must provide the Covered Person with an IMR application form together with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause a Covered Person to forfeit any California statutory right to pursue legal action against us regarding the disputed health care service. It should be noted that we do not believe any such California statutory right exists which is applicable to it. For more information regarding the IMR process, or to request an application form, please contact us.

Eligibility. The California Department of Insurance will review the Covered Person's application for an IMR to confirm that:

1. a. The provider has recommended a health care service as Medically Necessary.

   b. The Covered Person has received urgent care or emergency services that a provider determined was Medically Necessary; or

   c. The Covered Person has been seen by a provider for the diagnosis or treatment of the medical condition for which he or she seeks independent review.

2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. The Covered Person filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If the grievance requires expedited review, the Covered Person may bring it immediately to the attention of the California Department of Insurance. It may waive the requirement that the Covered Person follow the *plan's* grievance process in extraordinary and compelling cases.

If a case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination as to whether or not the care is Medically Necessary. The Covered Person will receive a copy of the assessment made. If the IMR determines the service is Medically Necessary, we will provide benefits for the health care service.

For non-urgent cases the IMR organization designated by the California Department of Insurance must

provide its determination within 30 days of receipt of the Covered Person's application and supporting documents. For urgent cases involving imminent and serious threat to a Covered Person's health including, but not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the Covered Person's health, the IMR organization must provide its determination within three business days.

PREMIUM PROVISIONS

GRACE PERIOD
A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).

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 Certificate, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or the Certificate or to waive any of its provisions.

All statements made by the Policyholder or by a Covered Person in the absence of fraud, be deemed a representation and not a warranty. No such statement shall (avoid the insurance or reduce the benefits under the Policy or) be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder or Covered Person, except a fraudulent misstatement, be used at all to void the Policy or this Certificate after it has been in force for three years from the date of its issue, nor shall any such statement of any person eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

TIME LIMIT ON CERTAIN DEFENSES:
After this policy has been in force for a period of three years, no statement of the Policyholder contained in the application, and no statement relating to insurability made by any member eligible for coverage under

the policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement is made.

After three years from the date of issue of this Policy, no misstatement of the Policyholder, except fraudulent statement, made in his application shall be used to void the policy; and after three years from the effective date of coverage with respect to which any claim is made, no misstatement of any person eligible for coverage under the policy, except fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred commencing after expiration of such three years.

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 .

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 20**-** days after a covered loss occurs or begins or as soon as reasonably possible. Notice given by or on behalf of the Insured or Covered Person to us at our administrative office as shown on the cover page -of the Policy, or to our authorized agent, with information sufficient to identify the Insured or Covered Person is deemed notice to us. Notice should include the Policyholder's name and number and a Covered Person's name and address.

CLAIM FORMS:
Upon our receipt of a notice of claim, we will furnish to the claimant such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirement of this Policy as to proof of loss upon submitting within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

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. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

TIME OF PAYMENT OF CLAIMS:
Benefits payable under this Policy for a loss, other than a loss for which this Policy provides periodic payments will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss which this policy provides periodic payment will be paid Monthly and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS:
Benefits for a Covered Person's loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is in effect, such benefit shall be payable to the estate of the Covered Person. Any other accrued benefits unpaid at the Covered Person's death may, at our option, be paid either to such beneficiary or to such estate. All other Benefits will be payable to the Covered Person.

If any benefits under this policy shall be payable to the estate of a Covered Person, or to a Covered Person or beneficiary who is a minor or otherwise not competent to give a valid release. We may pay such benefit, up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by us to be equitably entitled thereto. Any payment made by us is good faith pursuant to this provision shall fully discharge us to the extent of such payment.

Subject to any written direction of a Covered Person in the application or otherwise all or a portion of any benefits provided by this Policy on account of hospital, nursing, medical, or surgical services may, at our option and unless the Covered Person requests otherwise in writing not later than the time of filing proofs of loss, be paid directly to the person or persons having paid for the hospitalization or medical or surgical aid, or to the hospital or person rendering those services; but it is not required that the service be rendered by a particular hospital or 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 at our own expense, shall have the right and opportunity to exam the person of the Covered Person when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

RECOVERY OF BENEFITS:
We reserve the right to recover from a Covered Person any benefits we have paid to him for injuries:
Received for a covered Accident under:

a. workers' compensation or similar statutory remedies available under law; or
b. Any employer's liability Insurance.

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.