Blanket Accident Insurance Certificate

ZURICH AMERICAN INSURANCE COMPANY
1299 Zurich Way
Schaumburg, Illinois 60196

This is a summary of the accident insurance **We** provide on behalf of the **Policyholder** to **You** if **You** are within a class of eligible persons described in Section I - Schedule and if the required premiums are paid when due.

THE INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES ACCIDENT COVERAGE ONLY

THIS IS A SUMMARY OF COVERAGE ONLY WHICH SUMMARIZES AND EXPLAINS THE PARTS OF THE POLICY WHICH APPLY TO YOU.

FOR ALL TERMS AND CONDITIONS OF COVERAGE, PLEASE REVIEW THE POLICY ISSUED TO THE POLICYHOLDER AND ON FILE WITH THEM AT THEIR PLACE OF BUSINESS. YOU CAN OBTAIN A COPY OF THE POLICY FROM THE POLICYHOLDER.

THIS CERTIFICATE IS NOT AN INSURANCE POLICY. IN THE EVENT OF A CONFLICT OF PROVISIONS BETWEEN THE POLICY AND THIS CERTIFICATE, THE PROVISIONS OF THE POLICY WILL GOVERN

.PLEASE READ THIS CERTIFICATE CAREFULLY

NON-PARTICIPATING

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SECTION I - SCHEDULE

I. **POLICYHOLDER**: Livingston County School District
127 E Adair Street
Smithland, KY 42081

II. POLICY NUMBER: MCB 0214341

III. POLICY INCEPTION DATE: August 1, 2016

IV. POLICY PERIOD: August 1, 2017 to August 1, 2018
(All Insurance begins and ends at 12:01 a.m. at the **Policyholder's** address)

V. CONTRACT SITUS: Kentucky

VI. ELIGIBILITY AND CLASSIFICATION OF INSUREDS:

The following individuals are eligible to become **Insureds** upon the submission of completed enrollment material, if required:

Class I: All Registered Students of the **Policyholder**.

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, and he or she is covered under more than one Class, **We** will pay only one benefit, the largest benefit.

VII. **COVERED ACTIVITY(IES)**:

Class I: While participating in any **Policyholder** sponsored and supervised student activities, excluding activities that are covered by the Kentucky High School Athletic Association catastrophic policy; traveling directly and interruptedly to and from such activity with other members as a group. Such travel must be supervised by an authorized representative of the school.

VIII. BENEFITS:

BENEFITS	CLASS COVERED	COVERAGE AMOUNT	FORM NUMBER
Accidental Death Benefit	All	$10,000	U-BMC-102-A KY (07/10)
Accidental Dismemberment Benefit	All	$20,000	U-BMC-102-A KY (07/10)
Exposure and Disappearance Benefit	All	$10,000	U-BMC-102-A KY (07/10)
Catastrophe Cash Benefit	All	$500,000 Initial Lump Sum: $104,000 Monthly Amount: $3,300 Number of Months: 120	U-BMC-125-A CW (07/10)
Accident Medical Expense Benefit with Sublimits	All	See Benefit Rider	U-BMC-180-A KY (01/15)
Heart Failure Benefit	All	$10,000	U-BMC-143-A CW (07/10)
Seat Belt/Air Bag Benefit	All	Seat Belt: $5,000 maximum Air Bag: $5,000 maximum	U-BMC-116-A KY (08/11)

IX. REPORTING AND NOTICE ADDRESSES:

Claim Reporting:
Claims Department
Specialty Benefits, Inc.
PO Box 2338
1712 Magnavox Way
Fort Wayne, IN 46801
Phone: 800-237-2917
Fax: 312-381-9077
Email: kk.PAClaims@kandkinsurance.com

X. PREMIUMS:

Benefits under the **Policy** are **Non-Contributory**.

SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

INSURED'S EFFECTIVE DATE

Your coverage under the **Policy** begins on the latest of:

1. the Policy Inception Date shown in the Schedule;
2. the date for which the first premium for **Your** coverage is paid; or
3. the date **You** become a member of an eligible class of persons as described in the ELIGIBILITY AND CLASSIFICATION OF INSUREDS section on the Schedule;

A change in **Your** coverage under the **Policy** due to a change in **Your** eligible class becomes effective on the later of:

1. when the change in **Your** eligible class occurs; or
2. if the change requires a change in premium, the date the first changed premium is paid.

However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

SECTION III – DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

Active means a member as defined by the **Policyholder** based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.

Certificate means this Blanket Accident Insurance Certificate.

Contributory means the **Insured** is required to pay all or a portion of the premium. Whether the benefits are **Contributory** or **Non-Contributory** is stated in the Schedule.

Covered Accident means an **Accident** that results in a **Covered Loss**.

Covered Activity(ies) means those activities set out in the COVERED ACTIVITIES section of the Schedule.

Covered Injury means bodily injury directly caused by **Accidental** means which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured** is insured under the **Policy** and participating in a **Covered Activity**, and results in a **Covered Loss**.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.

Insured means any person who is eligible for coverage under the **Policy** as provided in the ELIGIBILITY AND CLASSIFICATION OF INSUREDS section of the Schedule, and who completes the enrollment material, if required.

Limb means an arm or a leg.

Non-Contributory means the **Insured** is not required to contribute toward the premium. Whether the benefits are **Contributory** or **Non-Contributory** is stated in the Schedule.

Physician means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that **We** recognize or are required by law to recognize;

2. licensed to practice in the jurisdiction where care is being given;
3. practicing within the scope of that license; and
4. not related to **You** by blood or marriage.

Plan means the coverages and/or benefits selected in the Schedule.

Policy means the Blanket Accident Insurance Policy issued to the **Policyholder**.

Policyholder means the entity named as such in the Schedule.

Spouse means **Your** legally married **Spouse**.

We, **Us**, and **Our** means Zurich American Insurance Company or **Our** authorized representative.

You or **Your** means the **Insured** to whom a **Certificate** is issued.

SECTION IV – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
2. war or any act of war, whether declared or undeclared.
3. involvement in any type of active military service.
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease;
5. participation in the commission or attempted commission of any felony.
6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity.
7. being intoxicated while operating a motor vehicle.
   a. **You** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication.
8. being under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.
9. travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.
10. alcoholism, drug addiction or the use of any drug or controlled substance except as prescribed by a licensed medical provider operating within his or her scope of authority.
11. any condition for which **You** are entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.
12. **Your** riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.

SECTION V – GENERAL LIMITATIONS

Benefits are payable only for **Covered Losses** incurred as a result of participation in **Covered Activities**.

LIMITATION ON MULTIPLE COVERED LOSSES: If **You** suffer more than one **Covered Loss** as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

LIMITATION ON MULTIPLE COVERED ACTIVITIES: If **You** suffer a **Covered Loss** while participating in more than one **Covered Activity**, **We** will pay only one benefit, the largest benefit unless there is a specific written exception in the **Policy**.

LIMITATION ON MULTIPLE BENEFITS: If **You** can recover benefits under more than one of the Benefits stated in the Schedule, as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

LIMITATION ON MULTIPLE COVERED POLICIES: If **You** can recover benefits under more than one accident policy written by Zurich American Insurance Company, **We** will pay under only one policy, the policy which offers **You** the largest benefit.

SECTION VI – PREMIUMS

A. PREMIUMS: Premiums are due and payable to **Us** at the rates and in the manner described in the Schedule.

B. GRACE PERIOD: Premiums are due for the **Policy** on or before the premium due date or renewal date, whichever applies. If a renewal premium is not paid when it is due, there is a thirty-one (31) day Grace Period (the "Grace Period") to pay. During the Grace Period, the **Policy** will stay in force. There will not be a Grace Period if **We** have given notice, at least forty-five (45) days in advance, that **We** are going to terminate the **Policy**.

SECTION VII - TERMINATION OF INSURANCE

A. POLICY RENEWAL AND TERMINATION:

RENEWAL: The **Policy** will automatically renew for an additional twelve-month (12) period unless either party expresses its intent to terminate as specified herein.

TERMINATION BY POLICYHOLDER: The **Policyholder** may terminate the **Policy** by delivering to **Us** a written notice to end the **Policy** at least forty-five (45) days in advance of such termination. **We** will calculate and return the unearned premium, if any, using a standard short rate table. The **Policyholder** will send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

TERMINATION BY US: **We** may terminate the **Policy** by giving the **Policyholder** at least forty-five (45) days' notice of **Our** intent to terminate. Such notice will state the exact date the **Policy** will terminate. **We** will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records.

We may also, at any time, end the **Policy** for non-payment of premium on any premium due date if the payment is not received prior to the end of the Grace Period. **We** will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records.

Termination will be without prejudice to any claim which commenced prior to the effective date of termination.

SECTION VIII - HOW TO FILE A CLAIM

A. NOTICE: **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**, or as soon thereafter as reasonably possible. The notice must name **You** and the Policy Number. To request a claim form, the **Insured** or the beneficiary, or someone on their behalf may contact Specialty Benefits, Inc. at 800-237-2917 or by e-mail at kk.PAClaims@kandkinsurance.com. The notice must be sent to the address shown on the Schedule, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

B. CLAIM FORMS: **We** will send the claimant Proof of Covered Loss forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the Proof of Covered Loss form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a Proof of Covered Loss if sent within the time fixed below for filing a Proof of Covered Loss.

C. PROOF OF COVERED LOSS: Written Proof of Covered Loss, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish Proof of Covered Loss acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the Proof of Covered Loss**,** and the proof was provided as soon as reasonably possible.

SECTION IX - PAYMENT OF CLAIMS

A. TIME OF PAYMENT: **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the Proof of Covered Loss that is acceptable to **Us**.

B. WHO WE WILL PAY:

1. LOSS OF YOUR LIFE: **Covered Losses** resulting from **Your** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** estate.

2. ALL OTHER CLAIMS: Benefits are to be paid to **You**. **You** may direct in writing that all, or part of the Accident Medical Expense Benefit with Sublimits if applicable, will be paid directly to the party who furnished the service. The direction may be changed by **You** at any time up to the filing of the Proof of Covered Loss.

3. If **You** are a minor or otherwise not competent to give a valid release, benefits may be made payable to **Your** parent, guardian or other person actually supporting **You**.

4. Any payment **We** make will fully discharge **Us** to the extent of the payment.

SECTION X - GENERAL POLICY CONDITIONS

A. BENEFICIARIES: **You** have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. Unless an irrevocable beneficiary is named, **You** may change the beneficiary at any time unless he or she has assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed. Any beneficiary designation must be in writing on a form acceptable to **Us**.

B. CHANGE OR WAIVER: A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

C. CLERICAL ERROR: A clerical error or omission will not increase or continue **Your** coverage, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

D. SUIT AGAINST US: No action on the **Policy** may be brought until sixty (60) days after written Proof of Covered Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written Proof of Covered Loss was required to be submitted. If the law of the state where **You** live makes such limit void, then the action must begin within the shortest time period permitted by law.

E. PHYSICAL EXAMINATION AND AUTOPSY: **We** have the right to examine **You** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

F. CHOICE OF SERVICE PROVIDER: **You** have the sole right to choose **Your** duly licensed **Physician** and hospital.

G. TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, statements made by the **Policyholder** or **You** are deemed representations and not warranties. No such statement will cause **Us** to deny or reduce the benefits due under the **Policy** or be used as a defense of a claim, unless it is contained in a signed written application. After two years from the date coverage starts no such statement (except age) will cause the **Policy** to be contested.

H. NEW ENTRANTS: All new students in the groups or classes eligible for insurance under the **Policy** will be added to such eligible groups or classes from time to time.

SECTION XI – BENEFITS

ACCIDENTAL DEATH BENEFIT

If **You** suffer a loss of life as a result of a **Covered Injury**, **We** will pay the applicable amount shown in the Schedule. The death must occur within 365 days of the **Covered Injury**.

ACCIDENTAL DISMEMBERMENT BENEFIT

If a **Covered Injury** to **You** results in any of the following **Covered Losses**, **We** will pay the percentage shown below. The **Covered Loss** must occur within 365 days of the **Covered Accident**.

The benefit amount is based on the maximum amount shown in the Schedule for the person suffering the **Covered Loss**.

Covered Loss of	Percentage of Maximum Amount
Both Hands or Both Feet	100%
One Hand and One Foot	100%
One Hand or One Foot plus the loss of Sight of One Eye	100%
Sight of Both Eyes	100%
Speech and Hearing	100%

Speech or Hearing	50%
One Hand; One Foot; or Sight of One Eye	50%
Thumb and Index Finger of the same Hand	25%
Hearing in One Ear	25%

For purposes of this Benefit, DEFINITIONS is amended to include the following:

Covered Loss means:

1. For a foot or hand, actual severance through or above the ankle or wrist joint;
2. For thumb and index finger, complete severance through or above the metacarpophalangeal joint of both digits;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.

EXPOSURE AND DISAPPEARANCE BENEFIT

If **You** are exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable amount shown in the Schedule subject to all **Policy** terms.

If the conveyance in which **You** are riding disappears, is wrecked, or sinks, and **You** are not found within 365 days of the event, **We** will presume that **You** lost **Your** life as a result of injury. If travel in such conveyance was covered under the terms of the **Policy**, **We** will pay the applicable amount shown in the Schedule, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that **You** survived the event.

Catastrophe Cash Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** within 365 days of a **Covered Accident** that results in **Paralysis**, **Coma** or **Brain Death**, **We** will pay a benefit as described below, provided that the **Paralysis**, **Coma** or **Brain Death**:

1. satisfies the **Benefit Waiting Period**;
2. must be determined by a **Physician** to be permanent and irreversible at the end of that **Benefit Waiting Period**; and
3. must result in **Disability**.

This benefit is payable based on the following table.

CAUSE OF DISABILITY	PERCENTAGE OF MAXIMUM AMOUNT(S)
Coma	100%
Paralysis of Two or More Limbs (Upper and/or Lower)	100%
Brain Death	100%
Paralysis of One Limb (Upper or Lower)	50%
Paralysis of One or More Other Parts of the Body	See below

NOTE: If the **Insured's Paralysis** is a part of the body other than a **Limb**, the percentage of the Maximum Amount used to determine the benefit payable will be adjusted in proportion to the comparable extent of **Paralysis** of the listed parts of the **Insured's** body.

If an **Insured** suffers more than one **Disability** as a result of the same **Accident**, only the largest PERCENTAGE OF MAXIMUM AMOUNT(S), will be used to determine the benefit payable.

The benefit payable is:

INITIAL LUMP SUM THEN MONTHLY:

The initial lump sum amount contained in the Schedule based on the PERCENTAGE OF MAXIMUM AMOUNT(S), payable after the **Benefit Waiting Period**, followed by a monthly benefit stated in the Schedule, starting one month after the end of the **Benefit Waiting Period**. The monthly benefit is payable monthly as long as an **Insured** remains continuously **Disabled** due to the **Paralysis**, **Coma** or **Brain Death**, but ceases on the earlie(r/st) of:

1. the date the **Insured** dies;
2. the date the **Insured** is no longer **Disabled** due to the **Paralysis**, **Coma** or **Brain Death**; or
3. the date monthly benefits have been paid for the maximum number of months shown in the Schedule for all **Disabilities** cause by the same **Accident**.

If the **Insured** returns to any occupation for which he or she is qualified by reason of education, experience or training on a full or part-time basis, or engages in any of the usual activities of a person of like age and sex in comparable health, he or she may return to **Disability** status if:

1. the **Insured** has not been engaging in such activities for longer than thirty (30) days; and
2. the attending **Physician** certifies a return to **Disability** status due to the same **Paralysis**, **Coma** or **Brain Death** which caused the original **Disability**.

We reserve the right, at the end of the **Benefit Waiting Period** (and as often as it may reasonably require thereafter) to determine, on the basis of all the facts and circumstances, that the **Insured** is **Disabled** due to the **Paralysis**, **Coma** or **Brain Death**, including, but not limited to, requiring an independent medical examination at **Our** expense.

For the purposes of this benefit only, the following DEFINITIONS apply:

Benefit Waiting Period means six (6) consecutive months at the start of a period of **Disability** for which **We** will not pay benefits.

Brain Death means irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain even though the heart is still beating.

Coma means a profound state of unconsciousness from which the **Insured** cannot be aroused to consciousness, even by powerful stimulation, as determined by a **Physician**.

Disabled/Disability means that due to a **Covered Injury**, the **Insured** is unable while under the regular care of a **Physician** to perform the material and substantial duties of the occupation for which he or she is qualified by reason of education, experience or training. However, with respect to an **Insured** for whom an occupational definition of **Disabled/Disability** is not appropriate, **Disabled/Disability** means that the **Insured** is unable, while under the regular care of a **Physician**, to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the **Insured** immediately prior to the **Accident**. Periods of **Disability** separated by less than thirty (30) consecutive days will be considered one period of **Disability** resulting from the same **Covered Injury**, unless due to separate and unrelated causes.

Paralysis means the complete loss of function in a part of the body as a result of neurological damage, as determined by a **Physician**.

This Catastrophe Cash benefit is subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: August 1, 2017 Attached to and forming a part of **Policy** No. MCB 0214341

Accident Medical Expense Benefit with Sublimits

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

SCHEDULE

Benefit	Maximum Benefit per **Insured** per **Covered Accident**	**Deductible** per **Insured** per **Covered Accident**	Co-Insurance: **Our** share of **Usual and Customary Expenses** per **Insured** per **Covered Accident**
Accident Medical	$7,500,000	$25,000	100%

We will pay **Our** share of the **Usual and Customary Expenses** for **Medically Necessary Covered Medical Service(s)** incurred by the **Insured** resulting from a **Covered Accident** while participating in a **Covered Activity**, up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the **Deductible** and subject to the co-insurance shown in the above Schedule provided that:

1. the first treatment or service occurs within one hundred eighty (180) days of the **Covered Injury**; and
2. the medical expenses are incurred within five hundred twenty (520) weeks of the **Covered Injury.**

For this benefit only, the following definitions apply:

Covered Medical Service(s) means any of the following services:

1. **Hospital** room and board expenses: the daily room rate when an **Insured** is **Hospital Confined** and general nursing care is provided and charged for by the **Hospital**. In computing the expenses payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary or miscellaneous inpatient **Hospital** expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when **Hospital Confined**.
3. Medical emergency care (room and supplies) expenses incurred within seventy-two (72) hours of an **Accident** and including the emergency room or attending **Physician's** charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility (including ambulatory surgical facilities).
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. **Physician** non-surgical treatment/examination expenses (excluding medicines) including the **Physician's** initial visit, each necessary follow-up visit and consultation visits when referred by the attending physician.
7. **Physician's** surgical expenses: If a **Covered Injury** requires singular or multiple surgical procedures during the same operative session through the same or different incision, **We** will pay only one benefit, the largest of the procedures performed.
8. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a **Physician's** surgical procedure whether on an inpatient or outpatient basis. The **Physician**'s surgical procedure(s) must be the result of a **Covered Injury**.
9. Assistant **Physician** expenses.
10. The services of a Registered Nurse (the nurse cannot be a member of the **Insured's** immediate family).

11. Physiotherapy expenses on an inpatient or outpatient basis limited to one (1) visit per day to a maximum of sixty (60) visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy and/or occupational therapy.
12. Non-emergency inpatient and outpatient X-ray expenses (including reading charges) but not for dental X-rays unless **Medically Necessary** to evaluate a **Covered Injury**.
13. Radiological procedures including: cardiac imaging and nuclear medicine and molecular imaging related to a **Covered Injury** and prescribed by a **Physician**.
14. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan related to a **Covered Injury** and prescribed by a **Physician**.
15. Ambulance expenses for transportation from the emergency site to the **Hospital**.
16. Rehabilitative limb braces, wheelchairs and other medical equipment or appliances prescribed by a **Physician** and related to the **Covered Injury**. It must be durable medical equipment that:
    a. is primarily and customarily used to serve a medical purpose;
    b. can withstand repeated use; and
    c. generally is not useful to a person in the absence of injury.

    No benefits will be paid for rental charges in excess of the purchase price.

    We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs.
17. Eyeglasses, contact lenses or hearing aids damaged or destroyed as a result of a **Covered Injury** and prescribed by a **Physician**.
18. Prescription drug expenses for **Covered Injuries**, prescribed by a **Physician** and administered on an outpatient basis.
19. Expenses for blood, blood transfusions and oxygen (including delivery of tanks and equipment and its administration).
20. Dental treatment for teeth, gums or structures directly supporting the teeth performed as a result of a **Covered Injury**.
21. Treatment resulting from complications of pregnancy due to a **Covered Injury**.
22. Any home health services performed by a licensed home health agency, prescribed by a **Physician** in lieu of **Hospital** or skilled nursing facility services, not to exceed 60 days per calendar year.

Custodial Services means medical and non-medical care, including services which are:

1. related to watching or protecting the **Insured** if as a result of a **Covered Injury** they are deemed by a **Physician** to require daily preventative care for a period of one (1) to ninety (90) days;
2. related to performing, or assisting the **Insured** in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be either self-administered or require medical assistance;
3. performed by trained or skilled medical personnel; and
4. which, in the absence of inpatient hospital care, would otherwise be required.

Deductible means a dollar amount of the **Usual and Customary Expenses** which must be incurred as an out-of pocket expense, by an **Insured** for each **Covered Injury**, before benefits are payable under this Policy. The **Deductible** amount is shown on the Schedule.

Hospital means an institution which:

1. operates pursuant to applicable local laws and regulations governing such facilities;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of Registered Nurses (R.N.) or graduated nurses.

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism or substance abuse.

However, a place for the treatment of mental illness, alcoholism or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the requirements in subparagraphs 1 - 4 above; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

Hospital Confined means admission to a **Hospital** as an inpatient for at least 24 consecutive hours by a **Physician**. A **Hospital** stay that does not result in charges to the **Insured** is not a hospital confinement under this rider unless there is no charge because the **Hospital** is a United States government facility.

In Force Policy means any multiple group, group-type, family or individual health care policy covering the **Insured** and in effect at the time of the **Covered Injury**, or subsequently thereafter, other than the **Policy** to which this rider is attached.

Medically Necessary means that the medical service or treatment:

1. is for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed;
2. meets standards of medical practice; and
3. is ordered by a **Physician**.

Principal Residence means the legal domicile of the **Insured** in his or her location of permanent assignment.

Usual and Customary Expense(s) means an amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board or the fee set by the workers' compensation insurance fee schedule, if applicable; and (2) does not include charges that would not have been made if no insurance existed and (3) does not exceed the cost of a generic drug, if available. **We** will only pay up to 75% of a non-generic drug if a generic drug is available.

EXCLUSIONS:

In addition to the General Exclusions stated in the **Policy**, **We** will not cover expenses under this additional benefit for:

1. Cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**.
2. Any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Covered Injury**.
3. **Covered Injury** for which the **Insured** is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or any statutorily mandated coverage.
4. Personal comfort or convenience items, such as **Hospital** telephone charges, television rental, guest meals, or internet charges.
5. Treatment by any immediate family member or member of the **Insured's** household.
6. Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless **Medically Necessary** for the treatment of the **Covered Injury**.
7. Expenses incurred for eye examinations, contact lenses or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Covered Injury**.
8. Routine physical examinations and related medical services, or elective treatment or surgery, or experimental or investigative treatments or procedures.
9. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
10. Expenses which the **Insured** is not legally obligated to pay.
11. Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury,** as prescribed by a **Physician**.
12. Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the **Covered Injury** has caused further impairment of the underlying bodily condition.

13. Treatment for osteochondritis due to overuse and occurring during periods of rapid growth, including Osgood-Schlatter Disease.

EXCESS INTEGRATED

The benefit amount for this benefit is payable in excess of any **In Force Policy** and its applicable deductible. In the event and only in the event of the reduction or exhaustion of the limit of insurance of the **In Force Policy** solely as the result of actual payment of benefits covered thereunder, this **Policy** shall pay excess of the reduced limit of insurance of the **In Force Policy** and its applicable deductible. This **Policy** shall only pay pursuant to the terms and conditions of this **Policy** and no other policy.

We will pay **Our** share of the **Usual and Customary** amount, reduced by the payment of any other insurance plan. This **Policy** will recognize payment by any other insurance plan as reducing or satisfying the deductible amount of this **Policy**. In no event will **We** pay more than the maximum amount stated in this rider.

If no **In Force Policy** exists, this **Policy** will pay benefits on a primary basis subject to the deductible and coinsurance amounts stated on the Schedule.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: August 1, 2017 Attached to and forming a part of **Policy** No. MCB 0214341

Heart Failure Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** as a result of a **Covered Accident**, which is a result of a **Heart Failure**, **We** will pay an additional amount shown in the Schedule. The **Heart Failure** must occur within twenty-six (26) weeks of the **Covered Accident**.

For the purposes of this benefit only, the following DEFINITION applies:

Heart Failure means death because the heart ceases to beat due to failure of the heart to maintain adequate circulation of blood provoked by participation in a **Covered Activity**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: August 1, 2017 Attached to and forming a part of **Policy** No. MCB 0214341

Seat Belt/Air Bag Benefit

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Benefit, and the **Covered Injury** which caused the **Accidental** death directly resulted from a motor vehicle **Covered Accident**, **We** will pay an additional Seat Belt Benefit, which equals the amount shown on the Schedule, provided that the **Insured** was:

1. operating or riding as a passenger in any private passenger motor vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Covered Injury**.

Verification of the **Insured's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the motor vehicle **Covered Accident**, through certification by the investigating officers; or
2. by other reasonable proof.

An additional Air Bag Benefit equal to the amount shown on the Schedule, will be paid if the **Insured** was driving a private passenger motor vehicle with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger motor vehicle with a manufacturer equipped passenger-side air bag, provided the **Insured's** seat belt or lap and shoulder restraint was properly fastened at the time of the motor vehicle **Covered Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the motor vehicle **Covered Accident**, through certification by the investigating officers or by other reasonable proof.

We will not pay a Seat Belt or Air Bag Benefit to the **Insured** that was driving either:

1. under the influence of alcohol:
   a. An **Insured** will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the motor vehicle **Covered Accident** occurred;
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication; or
2. under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.

This rider is subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: August 1, 2017 Attached to and forming a part of **Policy/Certificate** No. MCB 0214341

SANCTIONS EXCLUSION ENDORSEMENT

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY

The following exclusion is added to the policy to which it is attached and supersedes any existing sanctions language in the policy, whether included in an Exclusion Section or otherwise:

SANCTIONS EXCLUSION

Notwithstanding any other terms under this policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any insured, beneficiary, or third party who may have any rights under this policy to the extent that such coverage, payment, service, benefit, or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

The term policy may be comprised of common policy terms and conditions, the declarations, notices, schedule, coverage parts, insuring agreement, application, enrollment form, and endorsements or riders, if any, for each coverage provided. Policy may also be referred to as contract or agreement.

We may be referred to as insurer, underwriter, we, us, and our, or as otherwise defined in the policy, and shall mean the company providing the coverage.

Insured may be referred to as policyholder, named insured, covered person, additional insured or claimant, or as otherwise defined in the policy, and shall mean the party, person or entity having defined rights under the policy.

These definitions may be found in various parts of the policy and any applicable riders or endorsements.

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED

Privacy Notice

We Take Important Steps to Protect the Personal Information We Collect About You

Dear Customer: ***rev. October 2016***

We care about your privacy. That is why we believe in your right to know what nonpublic personal information we collect about you and what we do with that information. This Privacy Notice describes the nonpublic personal information we collect about you and how we handle the information as it relates to individuals who either own or are covered by insurance we issue, or who use other financial products or services we provide.

Overview	UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION

Why are you receiving this Notice?	Financial institutions, which include the Company, choose how they share your personal nonpublic information. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your nonpublic personal information. You are receiving this Privacy Notice because our records show either that you are the owner of an insurance policy or you are (or are authorized to act on behalf of) a current insured, future beneficiary and/or claimant under a policy, product or services issued by the Company.

What types of Information do we collect?	The types of nonpublic personal information we collect and share depend on the product or service you have with us. For example, this information can include: • Information about you we receive from you on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, employment information, information about your income, medical information; • Information about your transactions with the Company and its affiliates; • Information about your claims history; • Data from insurance support organizations, government agencies, insurance information sharing bureaus; • Property information and similar data about you or your property; and • Information we receive from a consumer reporting agency, such as a credit report. When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.

What do we do with the nonpublic personal information we collect?	WE SHARE YOUR NONPUBLIC PERSONAL INFORMATION IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS OR SERVICES, AS AUTHORIZED BY LAW, OR WITH YOUR CONSENT. THIS INCLUDES SHARING, AS PERMITTED BY LAW, YOUR NONPUBLIC PERSONAL INFORMATION WITH AFFILIATED PARTIES AND NONAFFILIATED THIRD PARTIES, AS APPLICABLE, IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS. IN THE SECTION BELOW, WE LIST THE REASONS WE CAN SHARE YOUR NONPUBLIC PERSONAL INFORMATION, WHETHER WE ACTUALLY SHARE YOUR NONPUBLIC PERSONAL INFORMATION, AND WHETHER YOU CAN OPT OUT OF THIS SHARING (OR IF YOU ARE A RESIDENT OF VERMONT, WHETHER YOU HAVE THE RIGHT TO OPT IN TO ALLOWING THIS SHARING).

Reasons we may share your personal information	Does Company Share?	Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing?
For our everyday business purposes – to affiliates and non-affiliates to process your transactions, administer insurance coverage, products or services, maintain your account and report to credit bureaus	Yes	No
For our marketing purposes or for joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – transaction and experience information	Yes	No
For our affiliates' everyday business purposes – creditworthiness	No	No
For our affiliates to market to you	Yes	No
For non-affiliates to market to you	No	We don't share

Collecting and safeguarding information	
How often does the Company notify me about their practices?	We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision.
Why and how does the Company collect my nonpublic personal information?	We collect nonpublic personal information when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. We collect personal information from: • Applications, forms and telephone, web site or written contact with you. This information can include social security number, driver's license number and income. • Your transaction(s) with us, our affiliates and other non-affiliated third parties. Transactional information includes such things as your insurance coverage, premiums, claims and payment history. Non-affiliated third parties may include appraisers, investigators, insurance companies, etc. • Information from physicians, hospitals and other medical providers. We collect this information only in connection with the issuance of individual or group insurance policies on your life or health, and with the processing and adjustment of claims under that insurance. Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.
What nonpublic personal information does the Company disclose?	We may provide to an affiliated or non-affiliated party the same nonpublic personal information listed above in the section entitled, "What information do we collect?".

How does the Company safeguard my nonpublic personal information?	Employees who have access to your nonpublic personal information are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards.

FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:

You have the following individual rights under state law:

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information you must submit a written request reasonably describing the information you seek, and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information. If you request medical records, we may elect to supply that information to you through your designated medical professional. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once in writing, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You must make your request in writing and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.

FOR RESIDENTS OF MASSACHUSETTS ONLY: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

Key words and phrases	TERMS YOU SHOULD KNOW

Definitions	
Everyday business purposes	The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as: • Processing transactions, mailing and auditing services • Administering insurance coverage, product, services or claims • Providing information to credit bureaus • Protecting against fraud • Responding to court/governmental orders or subpoenas and legal investigations • Responding to insurance regulatory authorities
Affiliates	Financial or nonfinancial companies related by common ownership or control. • *Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.*

Non-affiliates	Financial or nonfinancial companies not related by common ownership or control. We do not rent or sell your nonpublic personal information. However, we may share your information with companies that we hire to perform business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we disclose information to others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the business services. • *Company does not share information with non-affiliates to market to you*.
Joint marketing	A formal agreement between non-affiliated financial companies that together market financial products or services to you. • *Company does not jointly market.*

Changes to this Privacy Notice; contact us	We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes. If you have any questions about your contract with us, you should contact your agent. If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.

This Privacy Notice is sent on behalf of the following affiliated companies:

American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (hereinafter individually and collectively referred to as "Company").